



First Steps Manual

Washington State Department of Social and Health Services: Health
and Recovery Services Administration

Washington State Department of Health: Maternal and Infant Health

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In the Microsoft Word version of this manual, you can also link directly to other areas within the manual or to websites by pressing **CTRL+click** whenever you see blue, underlined text, such as the First Steps website:

<http://maa.dshs.wa.gov/firststeps>

If you are viewing a PDF version of this manual, you will also be able to click blue, underlined text to open website links. Internal hyperlinks cannot be clicked to jump directly to the area in the manual, but are accessible as bookmarks in a tab on the left-hand side of the window.

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Introduction

The First Steps Manual is meant to serve as a desk reference for Maternity Support Services (MSS), Infant Case Management (ICM) and Childbirth Education (CBE). It also provides general information about other related services. This manual replaces the *ABCs Manual* and is available electronically at: <http://maa.dshs.wa.gov/firststeps>

Please note if you are not viewing this manual on the First Steps website, you may not have the most current information.

The vision for this manual is that providers will have current information about First Steps policies, procedures, and requirements in one place so it is more convenient for providers to can provide quality services to First Steps clients. We are currently working with DSHS to convert the First Steps Manual into an electronic format that will be easier to search, link with manuals for other DSHS programs and allow you to review related RCWs and WACs.

This manual will undergo revisions periodically. First Steps staff members are welcome to send their comments and suggested changes to their county leads for consideration towards periodic manual revisions. If you notice an error in the manual, please contact Becky Peters by phone at (360) 236-3532 or by email at rebecca.peters@doh.wa.gov

The state First Steps Team hopes this manual is helpful and looks forward to hearing from you about how to improve it.



There are two sections in [Appendix VII](#) that you may wish to review prior to reading the manual: [Definitions](#) used in this manual and others related to the Medicaid program, and [Commonly Used Acronyms](#).

First Steps Overview

This section of the manual covers the history and goals of First Steps as well as an overview of First Steps services: Maternity Support Services (MSS) and Infant Case Management (ICM).

History of First Steps

Late 1980s

During the late 1980s, women across Washington State faced increasing difficulty in accessing prenatal care. Increasing malpractice premiums and low Medicaid reimbursement resulted in a shortage of obstetrical providers. Maternity care providers were increasingly reluctant to provide care to the growing number of Medicaid clients.

1985–87

Private practitioners, representatives of state agencies, public officials, and the University of Washington faculty recognized this crisis in maternity care and formed the Access to Maternity Care Committee, sponsored by the Washington Chapter of the American College of Obstetricians and Gynecologists. This committee was instrumental in identifying major causes of the maternity care crisis and in shaping the First Steps legislation.

1989

In 1989, the Washington State Legislature passed the Maternity Care Access Act. The result of this legislation was to expand eligibility for Medicaid during pregnancy to 185% of the federal poverty level, authorize MSS and MCM (Maternity Case Management) services, increase physician reimbursement for medical care, and initiate a public outreach campaign through the Healthy Mothers Healthy Babies coalition, now known as WithinReach. The Maternity Care Access Act also enabled pregnant women to receive expedited substance abuse assessment and treatment. [RCW 74.09.790]

2003

In 2003 the First Steps program underwent a major redesign to improve the service delivery module while containing costs.

Today

First Steps services today, including Maternity Support Services (MSS) and Infant Case Management (ICM), is a unique program located in Washington State that provides support services in addition to prenatal care to low-income pregnant women and infants. Enhanced services include transportation, interpreter services, childcare, childbirth education, and expedited eligibility determinations and referral to DASA (Division of Alcohol and Substance Abuse) services. Women who have received First Steps services can remain eligible for family planning only services through Medicaid through one year post pregnancy.

First Steps Program Overview and Goals

Overview

The First Steps program is managed collaboratively by the Washington State Department of Social and Health Services (DSHS) and the Washington State Department of Health (DOH). DSHS is accountable to the federal Medicaid program and provides Medicaid funding for all First Steps services. Administration of the program is shared jointly with DSHS and DOH through an inter-local agreement and delegation of authority by DSHS to DOH.

First Steps services are provided by a network of contracted agencies in every county. Both public and private agencies across Washington State have contracted to provide MSS/ICM services.

Goals

The MSS/ICM portion of the First Steps Program provides enhanced support services to eligible pregnant women through the maternity cycle and for high risk infants and their families through the month of the infant's first birthday. MSS/ICM services are designed to provide interventions as early in a pregnancy as possible to promote a healthy pregnancy and positive birth and parenting outcomes.

Additional program goals:

- Decrease health disparities.
- Reduce the number of unintended pregnancies.
- Reduce the number of repeat pregnancies within two years of delivery.
- Increase the initiation and duration of breastfeeding.
- Reduce tobacco use during pregnancy and pediatric exposure to second-hand smoke;
- Reduce risky behaviors associated with SIDS.
- Improve pregnancy and post-pregnancy nutritional status through individualized nutrition therapy.
- Increase self-sufficiency of the mother and family unit.

Measures of Improvement

Measures of improvement in pregnancy and parenting outcomes include:

- An increase in early access and ongoing utilization of prenatal and newborn medical care.
- A decrease in low birth weight babies.
- A decline in infant mortality rates.
- A decline in maternal morbidity and mortality.

Maternity Support Services (MSS) Overview

Maternity Support Services are preventive health services designed to supplement medical visits and include screening, assessment, education, intervention and brief counseling. Other covered services include medical care, dental care, child care, transportation, interpreter services, specialized substance abuse treatment, and childbirth education.

MSS Provider Roles

Maternity Support Services are provided by an interdisciplinary team of community health nurses, registered dietitians, behavioral health specialists, and in some agencies community health workers. See the section [Discipline Specific Qualifications and Job Descriptions](#) for specific qualifications for these specialists.

MSS Eligibility

The eligibility period for MSS begins during pregnancy and continues to the end of the month in which the 60th day post-pregnancy occurs. Women must also be enrolled in Medicaid.

Medicaid eligibility for a client must be determined prior to the end of the pregnancy. All pregnant women who are at or below 185% of the federal poverty level (FPL) are eligible for Medicaid. An accelerated application process is available through a Community Service Office (CSO) or call center. To locate the closest CSO, please see:

<https://www2.wa.gov/dshs/onlinecso/findservice.asp>.

Teens living with their family can be qualified on their own personal income. Women who receive their medical care through a managed care plan such as the Healthy Options program are also eligible. Full medical and dental coverage is available for pregnant and post-pregnant women who are non-citizens, and, they are exempt from Healthy Options.

DSHS Medical Identification Card

For a woman who already receives Medicaid coverage, her DSHS Medical Identification (ID) card must have one of the following identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP—CHIP	Categorically Needy Program— Children's Health Insurance Program
CNP—Emergency Medical Only	Categorically Needy Program- Emergency Medical Only

This is a sample of the medical card showing the CNP identifier circled in red:

Please read back of this card

Washington State
Department of Social
& Health Services

MEDICAL IDENTIFICATION CARD
This Card Valid From: 10-01-08 To: 10-31-08

P.O. Box 45531
OLYMPIA, WA 98504-5531

11/27/01

PATIENT IDENTIFICATION CODE				MEDICAL COVERAGE INFORMATION								
State	Identifier	Last Name	TS	Insurance	Medicaid	HMO	Out-of-Pocket	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
WA	010171	DOE	A									

JANE D. DOE
114 THIS LANE, APT. 1
VANCOUVER, WA 98685

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE

CNP
076 007508080
RD0011754

[Signature]
SIGNATURE (NOT VALID UNLESS SIGNED)



If the client is pregnant but her card does not list one of the above medical program identifiers, please refer her to the local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

MSS Billing

Maternity Support Services are reimbursed on a fee-for-service basis. All eligible women may receive up to 60 “units” of care (one unit = 15 minutes). Please see the MSS/ICM Billing Instructions at <http://maa.dshs.wa.gov/download/publicationsfees.htm> for more information on what services can be billed.

Infant Case Management (ICM) Overview

The Infant Case Management program serves high-risk infants and their biological parents. The goal of ICM is to improve the self-sufficiency of the birth parents in accessing needed medical, social, educational and other services.

ICM Eligibility

Eligibility for ICM may be documented anytime during the ICM service period (which is from the end of the maternity cycle, month three through the month of the infant’s first birthday).

Eligibility Criteria

- The infant must live with his or her biological parent(s).

- The infant or parent meets at least one of the high risk eligibility criteria listed on the ICM Intake form (DSHS form # 13-658: http://www1.dshs.wa.gov/dshsforms/forms/13_658.pdf)
- The infant must have his or her own medical identification card with one of the following identifiers: CNP, CNP Children's Health, CNP-CHIP, or CNP-Emergency Medical Only.
- There must be documentation noting that the birth parent cannot access needed services without assistance.

ICM Billing

Infant Case Management is paid on a fee-for-service basis. Eligible clients may receive up to 40 "units" of care (one unit = 15 minutes). Please refer to the MSS/ICM Billing Instructions at <http://maa.dshs.wa.gov/download/publicationsfees.htm> for more information on what services can be billed.

First Steps Services Overview

First Steps Services		
MSS Maternity Support Services	ICM Infant Case Management	
ALL pregnant women covered by Medicaid	Who gets it?	Infants at high-risk who are Medicaid eligible and reside with a biological parent
Preventative Health Services: <ul style="list-style-type: none"> • Assessment • Education • Intervention • Case Management <ul style="list-style-type: none"> • Referrals • Linkages • Advocacy 	What do they get?	Referrals, linkages and advocacy
Pregnancy to two months post-pregnancy	When do they get it?	Infants from three to 12 months old
<ul style="list-style-type: none"> • Community Health Nurse • Registered Dietitian • Behavioral Health Specialist • Community Health Workers 	Who does it?	A member of the MSS team OR Paraprofessional staff who are ICM qualified
Offices in which a social or health agency resides, homes, and other places	Where does it happen?	Offices in which a social or health agency resides, homes, and other places

First Steps Provider Agency Requirements and Administration

This section identifies the requirements that all First Steps provider agencies must adhere to. Only approved provider agencies may provide Maternity Support Services and Infant Case Management (MSS/ICM) services. The First Steps Management Team (FSMT), comprised of both DSHS and DOH First Steps staff and managers, has the authority to approve or deny applications to become a First Steps provider. The conditions under which new providers will be considered are described in [Appendix VIII, New First Step Providers and Expansion by Current Providers](#).

Provider Agency Requirements

All First Steps provider agencies must comply with the required assurances and the content of the core provider agreement.

Required Assurances

The Assurance Agreement describes what the provider must do to comply with Medicaid requirements and the specific provisions of the program.

Maternity Support Services and Infant Case Management Staffing

Provide Community Health Nurse, Behavioral Health Specialist, and Registered Dietitian (an interdisciplinary team) services for the maternity cycle plus staff (if different) for the infant case management services (Community Health Worker services is optional). Tribes or counties with less than 55 births in 2001 are not required to have all members of the interdisciplinary team. These providers may provide community health nursing services only.



Providers with only Community Health Nursing are encouraged to consult with the professionals in the other disciplines at another First Steps agency when possible.

Ensure that all staff meets the minimum qualifications. Any staff not meeting the minimum qualifications must be approved by the state program to continue providing services after October 1, 2003 and must comply with the requirements set forth in their exception. (See the section on [Discipline Specific Staff Qualifications and Job Descriptions](#).)



Health & Recovery Services Administration (HRSA) considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment during a medical audit.

Comply with applicable clinical supervision/clinical consultation as specified in the staff job descriptions.

Notify state discipline specific consultant when staff person in that discipline joins or leaves apposition on the First Steps team.

Ensure all newly hired staff and subcontractors receive an orientation to First Steps as soon as possible, but no later than 60 days from hire date. (See [Appendix V, Staff Orientation.](#))

Support case conferencing and the time necessary to accomplish this activity.



Note: Background checks must be conducted on all First Steps staff upon employment and every two years thereafter. This has become a DSHS requirement since the assurances were written in 2003.

Core Services

- Provide both MSS and ICM services.
- Provide MSS/ICM services in the office, home and non-office setting.
- Promote client participation in developing and implementing the service plan.
- Provide MSS and ICM services as described in the [Core Services](#) section of this manual.

Performance Measures

Develop and maintain a local continuum of care that ensures each client is informed of local family planning services as required by the [Family Planning \(Unintended Pregnancy Prevention\) Performance Measure.](#)

Address tobacco use and secondhand smoke exposure as required by the [Tobacco Cessation During Pregnancy Performance Measure.](#)

MSS/ICM Coordinator

Identify a MSS/ICM Coordinator within the agency. A description of desirable qualifications and expected duties can be found later in this section: [First Steps Coordinator Roles and](#)

[Responsibilities](#). Providers must notify the DOH First Steps Administrative support staff when the coordinator changes. See [Appendix III](#) for [State Contacts by Agency and Topic](#).

Ensure that the coordinator has electronic communication (HTML) capacity.

Standardized Charting for Documentation

Actively participate in state efforts to develop MSS/ICM standardized charting and documentation. Once developed, integrate the final versions into the agency's record keeping system. Agencies must have an approved exception on file with the state First Steps staff to use alternate documentation forms.

Linkage with Community Agencies

Maintain collaborative efforts with other community providers/resources.

Develop and maintain Memorandum of Understanding with local WIC program(s) to enhance coordination of nutrition services. Note: This is not required as of 2006 although it was part of the 2003 assurances.

Quality Assurance

Comply with on-going quality assurance requirements:

- Regular self-monitoring requirements
- Participate in state program monitoring /evaluation activities as scheduled
- Support training for the program coordinator and program staff

Core Provider Agreement

The Core Provider Agreement describes what is required to be assigned a Medicaid provider number required for reimbursement. A copy of the core provider agreement is available in [Appendix VIII, Core Provider Agreement](#).

First Steps Administration

Billing and Reimbursement

Information describing what is reimbursable under the First Steps program and the fee schedule are found in the Maternity Support Services and Infant Case Management Services Billing Instructions at: <http://maa.dshs.wa.gov/download/publicationsfees.htm>. It is recommended that providers visit the website regularly to view numbered memos and revisions that occur over time. A memo is usually sent out through the First Steps Mailbox distribution list, and posted on the First Steps website and First Steps listserv alerting providers to changes. By downloading the billing instructions periodically providers will be sure to have the most current information.

Subcontracting Guidelines

A Maternity Support Services and Infant Case Management agency may subcontract for some of the required disciplines. The subcontractor is expected to comply with the same policies and

assurances as MSS/ICM agencies. The MSS/ICM agency must submit a signed copy of the written agreement developed with the subcontractor that addresses at a minimum the items described in these guidelines:

- Effective dates of the agreement and all necessary signatures.
- Assurance that the subcontractor and staff meet the required qualifications to provide the subcontracted service.
- A mechanism to provide the subcontractor with all pertinent information related to the MSS/ICM program including current billing instructions, training materials, memorandums and other correspondence from the state First Steps staff related to the delivery of services.
- An indication that the subcontractor is accountable for the applicable program assurances.
- Plan for the subcontractor and staff to receive an orientation to First Steps within the first 60 days of the subcontract effective date or hire date.
- A method for the recognized MSS/ICM agency to receive necessary information to submit billings to MAA for all services rendered by the subcontractor and a method for reimbursing the subcontractor, if applicable.



If both agencies have MSS/ICM provider numbers, they may bill separately but need to keep each other informed of the units billed. The provider agency using the subcontractor to fulfill program requirements is responsible for ensuring the subcontractor is providing services in keeping with the program requirements.

- Include the names of contracted staff on the MSS/ICM roster when submitted to the state team.
- A method of notifying state First Steps staff of contracted staff changes.
- Assure the subcontractor is informed of all training opportunities available to MSS/ICM staff.
- A description of the methods staff will use to fulfill the case conferencing requirement and how the service plan will be updated.
- Develop a mechanism for each party to have access to the entire client record related to MSS and ICM services while maintaining required confidentiality guidelines.
- Provide the subcontractor with all necessary forms to comply with charting and documentation requirements.

Additional Issues to Consider:

- Financial reimbursement
- Liability coverage
- History of business practices/ financial solvency
- Method for terminating agreement
- Method for handling disputes

The above list is not exhaustive but meant to identify the major areas of concern related to the delivery of MSS and ICM services where more than one entity is providing components of the service delivery model. These guidelines do not replace legal services in developing contracts or service agreements.

First Steps Coordinator Roles and Responsibilities

The coordinator must have access to electronic communication with HTML capacity. The coordinator shall be a professional with demonstrated skills and knowledge in the delivery of services to the maternal child health population. The MSS/ICM Coordinator assures that the MSS/ICM program is implemented according to the provisions described in the First Steps Manual, the revised HRSA Core Provider Agreement, and the MSS/ICM Billing Instructions.

The Coordinator establishes a mechanism to oversee the management and fiscal affairs of the MSS and ICM program which include the following:

- Organize and direct the ongoing function of client services.
- Ensure accurate documentation of client, personnel and billing records.
- Work with the state program consultants and other providers to implement standardized charting for documentation and continued quality improvement efforts.
- Assure accuracy of public information materials.
- Participate in the recruitment and retention of qualified staff, the implementation of staff orientation and training plans and a method to regularly evaluate staff performance.
- Assure that pertinent information (letters, memos and electronic communications) is disseminated to all agency staff providing, overseeing, or billing for MSS/ICM services.
- Implement a quality improvement plan to include identification and correction of problems in service delivery system, evaluation of client satisfaction, evaluation of client outcomes, and methods for processing complaints.
- Act as a liaison between the MSS/ICM agency and state agencies providing program management.
- Inform state First Steps MSS county lead of changes in agency contact person, agency name, mailing address, physical location, phone number, email address, service area or program capacity.
- Participate in community collaboration regarding delivery of MSS/ICM services.

Coordinator Meetings

Coordinator meetings are scheduled as time and resources allow. The coordinator meetings are designed to keep providers informed of what is going on at the state level, share information and data about specific topics, obtain input on issues faced by agencies, and network with others to share successes and challenges.

Age of Consent

Health Care

A person over the age of 18 has the ability to make decisions in regard to his or her own body, “including but not limited to consent to surgical operations.” [RCW 26.28.015(5)] Inferentially, a person under age 18 does not have the ability to consent to health care. This inference may also be deduced from [RCW 11.88.010(1)(e)], which provides that for purposes of giving informed consent for health care pursuant to [RCW 7.70.050] and [7.70.065], an incompetent person includes persons under the age of majority.



Disclaimer: Laws and rules can change and it is the responsibility of each provider to stay informed about what the most current ones require. The information above is not an interpretation of the law but an effort to summarize the content and provide a resource to agencies and individuals in need of this information.

However, persons under age 18 have the ability to consent to certain kinds of health care as a result of specific statutory provisions and, in the case of reproductive health care and emancipation, case law, such as:

Sexually-Transmitted Disease/HIV Testing

[RCW 70.24.110] allows minors 14 years of age and older to consent “to the furnishing of hospital, medical and surgical care related to the diagnosis or treatment” of a sexually-transmitted disease. If the minor alone consents to the procedure, then the parent or legal guardian is not responsible for payment. The minor’s medical record cannot be released to the parent/guardian without the minor patient’s authorization. [RCW 70.24.105]

Alcohol/Drug Abuse Treatment

Outpatient: Under RCW 70.96A.095, a minor 13 years of age and older may consent to outpatient treatment by a chemical dependency treatment program certified by the department. Parental authorization is required for any treatment of a minor under age 13. The consent of a minor is not required for evaluation if the parent brings the child to the provider. [RCW 70.96A.250(2)]

Inpatient: Under RCW 70.96A.235, parental consent is required for inpatient chemical dependency treatment of a minor, unless the child meets the definition of a child in need of services in RCW 13.32A.030(4)(c) as determined by the department. Parental consent is required for any treatment of a minor under age 13. The consent of a minor is not required for admission, evaluation, and treatment if the parent brings the minor in for inpatient treatment. [RCW 70.96A.245(2)]

Mental Health Treatment

Minors age 13 years of age and older may request and receive outpatient and inpatient mental health treatment under [RCW 71.34.030] and [71.34.042], respectively, without parental consent. For inpatient treatment, admission shall require the professional person in charge of the facility concur in the need for inpatient treatment. Parental authorization is required for outpatient treatment of a minor under age 13. The consent of a minor is not required for admission, evaluation, and treatment if the parent brings the minor to the inpatient facility. [RCW 71.34.052(2)]

Training

Training for the program coordinator and staff is offered and supported. The state program offers *ABCs of First Steps* as a web-based training course for new staff which is designed to supplement the orientation given within the agency. It includes opportunities for staff to build skills, increase knowledge of the First Steps program, and receive more specific information related to their discipline. This training is required of all new employees and must be completed during the 60 day orientation period. Documentation showing completion of this training shall be available during monitoring visits. DOH Learning Management System also keeps records of course completion.

Specific training on program topics such as core services, staff recruitment, basic health messages and documentation may be offered at various times in different formats as resources allow. All announcements of training opportunities will be posted on the First Steps website and listserv.

Annual Staff Roster

The agency must submit a staff roster listing all staff and subcontractors at least every twelve months. The roster must include the full name of staff members, descriptions of educational degree and years of experience in Maternal and Infant Health, as well as the number of hours each works in the First Steps program. The form and an example are available on the First Steps website: <http://fortress.wa.gov/dshs/maa/firststeps/NewClarCorner.htm>

Methods of Communication

First Steps state staff is committed to maintaining communications with providers in a timely and efficient manner. Several mechanisms have been developed to assist in keeping providers and other interested parties informed of the program.

See [Appendix III](#) for a list of [State Contacts by Agency and Topic](#).

First Steps State Contacts

MSS County Leads

There is a state consultant assigned to every county that offers Maternity Support Services (MSS). These consultants are called County Leads. They serve as the first point of contact for general information, questions and comments about First Steps. In addition these consultants provide discipline specific consultation and technical assistance to the entire state.

See [Appendix III](#) for a list of [MSS County Leads](#) and contact information.

ICM Program Manager

The ICM program manager provides oversight and consultation regarding ICM service delivery to all agencies in the state.

First Steps Listserv

1. This listserv is the First Steps Program's main method of communicating with all local program staff. Any interested person can sign up for the First Steps Listserv (not only a coordinator). The listserv contains general information about maternal and infant health issues, funding opportunities, training and other items of interest. There are also links to other related websites.
2. To sign up for the listserv, go to <http://listserv.wa.gov> and follow instructions. Be sure to reply to the first message from the listserv as that confirms the email address and sender's intention to sign up.
3. Anyone can request something be posted to the First Steps Listserv by contacting the First Steps Clearinghouse Program Manager. See [Appendix III](#) for [State Contacts by Agency and Topic](#).

The following protocol is used in choosing items to post to the listserv:

Topics of interest related to First Steps providers where the source of original information is one of the following:

- Established medical authority (e.g. Mayo Clinic, JAMA, Medline)
- DSHS/DOH Releases (e.g. MSS/ICM Announcements)
- University (National, State or established private)
- Federal Government (e.g. CDC, NIH, FDA, etc.)
- Other States
- Resources available to everyone
- Training offered by others (free or low-cost, non-profit)

Topics/Articles of questionable interest/reliability/applicability will be reviewed by at least one of the following before posting:

- Health and Recovery Services Administration Medical Staff
- RDA (Research and Data Analysis)
- DOH Staff

Informal surveys of First Steps users regarding usefulness/amount of postings to Listserv will be conducted periodically.

Websites

First Steps: <http://fortress.wa.gov/dshs/maa/firststeps/>

This website has information about the First Steps program for the public, consumers, and providers. Clarification Corner is intended for current providers. It is the home of the MSS/ICM Provider Directory and the First Steps Childbirth Education Provider Directory. State staff contact information and county lead assignments are also located in the Clarification Corner. Forms for updating directory information and staff rosters are available at this site. Staff is urged to visit this site regularly to stay informed about the program's current activities.

Billing Instructions: <http://maa.dshs.wa.gov/download/publicationsfees.htm>

This website contains billing instructions for Maternity Support Services and Infant Case Management, First Steps Childcare and Childbirth Education. A user's agreement may come up when accessing the DSHS website. Click **Accept** and proceed.

It is recommended that providers visit this site on a regular basis to ensure the billing instructions being used are the most current. For agencies providing MSS/ICM and Childbirth Education, there is no need to download both billing instructions. There is adequate information in the MSS/ICM billing instructions to complete both types of services.

DSHS Forms: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

This website contains DSHS forms. A user's agreement may come up when accessing the DSHS website. Click **Accept** and proceed.

The following forms can be accessed at this site:

- First Steps Initial Screening Form [DSHS 13-723] old version
- Infant Case Management Eligibility Criteria [DSHS 13-658]
- First Steps Childcare Background Authorization [DSHS 15-253]
- First Steps Childcare Billing Information [DSHS 14-316]

First Steps Email Message Box

1. The First Steps Email Message Box is the name of the email address that First Steps staff uses to communicate with Coordinators about important issues such as billing, training opportunities and time sensitive information. Coordinators are required to share all

information sent from the First Steps Email Message Box with their staff, subcontractors and administrators. In most cases, there is one person from each approved MSS/ICM provider agency on this distribution list.

2. Three main items in the subject category are:
 - Time Sensitive Action Required
 - Training Opportunity
 - Important: include a subject heading
3. Send responses, questions, and comments to items sent out from the email message box by contacting the person identified in the email or to the county lead. **DO NOT** click **Reply to All**. Simply click **Reply ONLY**.
4. Contact the DOH First Steps Administrative support staff with changes to the coordinator position and/or provider directory. See [Appendix III](#) for [State Contacts by Agency and Topic](#).
5. If email is not available for a period of time, please let the DOH First Steps Administrative support staff members know so that information can get to the agency on an interim basis. See [Appendix III](#) for [State Contacts by Agency and Topic](#).

First Steps MSS/ICM Provider Directory

This is a directory of MSS/ICM providers located on the First Steps website <http://maa.dshs.wa.gov/firststeps> for providers and community members trying to locate a First Steps provider in a given area of the state. Contact the DOH First Steps Administrative support staff with changes. See [Appendix III](#) for [State Contacts by Agency and Topic](#).

Childbirth Education Provider Directory (Under Development)

This is a directory of Childbirth Education providers across the state for use by community members, clients, and other providers. Contact the health education/community health worker/childbirth education consultant at DOH with changes. See [Appendix III](#) for [State Contacts by Agency and Topic](#).

First Steps Newsletter

The First Steps Newsletter is published every other month. It is sent to First Steps coordinators, the Listserv, and posted on the First Steps website.

Program Advisory Group (PAG)

The Program Advisory Group is comprised of ten representatives of First Steps provider agencies and several First Steps state staff. The group's purpose is to improve communication between state and local First Steps programs and create an opportunity for local providers to give input into First Steps policies. The Program Advisory Group is a way to exchange important information that affects the quality and effectiveness of the First Steps program.

First Steps Community Provider Groups

First Steps provider groups meet in most communities across the state and offer an opportunity for service coordination, resource sharing and collaboration building. First Steps agency providers, state First Steps staff as well as local or regional DSHS staff may attend these meetings. All providers are encouraged to attend these gatherings.

CSO Interface/Referrals

The First Steps/Family Planning Coordinators work with local Community Service Offices (CSOs), First Steps and Family Planning Agencies to ensure that the continuum and quality of care across both services are maintained. The Coordinators will also further relationships with CPS, Domestic Violence Providers, Substance Abuse Providers, and Mental Health Treatment Providers. See [Appendix III](#) for contact information for [CSO Coordinators](#) and [DASA Regional Administrators](#).

Core Services

This section covers the core services of the First Steps MSS/ICM program, the client centered approach and interdisciplinary/interagency model of care.

Client Centered Services

Services in First Steps are client centered and focus on improving pregnancy and parenting outcomes. Client-centered means that the client comes first in the service delivery relationship.

This approach includes:

- Delivering services in an environment where a client can expect understanding, respect, fairness, accurate information, convenience and results.
- Determining the pregnant woman's understanding of positive pregnancy and parenting health care practices through review of the First Steps Screening Tool and questionnaires if used.
- Providing health education and developing a plan for care, in collaboration with the pregnant woman and interdisciplinary team members, to support positive self-care, parenting practices and progress toward self-sufficiency.
- Addressing factors that could negatively affect the health of the pregnant woman and her unborn child or newborn infant.
- Using communication skills such as Motivational Interviewing to:
 - Expand the client's understanding of her situation;
 - Support and guide the woman by exploring risks and how those risks may affect her or her infant;
 - Discuss what she is willing to do to reduce or eliminate the risks; and
 - When she is ready, problem solve collaboratively to reduce barriers or access services to help her achieve her goals.
- Referring and linking the woman to appropriate services when situations of immediate risk to the life of the woman, infant or family are disclosed and/or recognized, i.e. domestic violence, suicidal ideation with a plan, child abuse, or neglect.

Client Responsibilities

The client:

- Decides the goals.
- Gains skills and knowledge needed to meet goals.
- Makes decisions about behavior change.

Staff Responsibilities

The First Steps provider:

- Alerts the client to potential benefits associated with healthy habits.
- Provides opportunities for the client to:
 - Work through their feelings about the topic;
 - Be encouraged and supported;
 - Value the new habit;
 - Acquire a sense that they can do it; and
 - Learn and develop skills.
- Develops a Plan for Care incorporating client priorities.
- Explains the agency's services clearly and how the services might meet the client's needs. The provider needs to convey the value in the MSS/ICM service and be able to identify what can be offered to the client.
- Checks in with the client on a regular basis to ensure needs are being met.
- Documents risk factors, interventions, and outcomes.

Tools for Client-Centered Services

These are some of the tools for client-centered services:

- Active Listening
- Motivational Interviewing
- Understanding the [*Stages of Change*](#)
- Providing services in an environment that is client centered
- Conducting a client satisfaction survey once the client is done receiving MSS/ICM services

When providers remain non-judgmental and open-minded, while listening and working to meet the client's needs, they will naturally keep a client engaged. As the client feels heard and their needs are addressed, trust will develop and the client will want to continue working with the provider.

Maternity Support Services

MSS client services include screening, assessment, education, brief interventions and case management that focus on promoting healthy pregnancy and positive early parenting outcomes. Services include the basic health messages, linkages, advocacy, referrals and minimum interventions for identified risk factors

Teamwork and Teaming

Maternity Support Services is based on the interdisciplinary team concept of care. An interdisciplinary team is a group consisting of individuals from different professions and occupations that work closely together and communicate frequently (case conferencing) to optimize care for the pregnant woman and infant. Each team member contributes specialized knowledge, skills and experience to support and augment the contributions of the other team members. The MSS team consists of community health nurses, registered dietitians and behavioral health specialists and in some cases community health workers. The team may also include health care providers and staff from other agencies who are also working with the client.

The team approach to care offers the services of specialists in a comprehensive and coordinated manner. The interdisciplinary team can achieve better outcomes than any individual member providing services alone. A successful team shares common treatment goals for the client and coordinates efforts through case conferencing to reduce duplication and maximize the time spent with the client.

Common Characteristics of Effective Teams

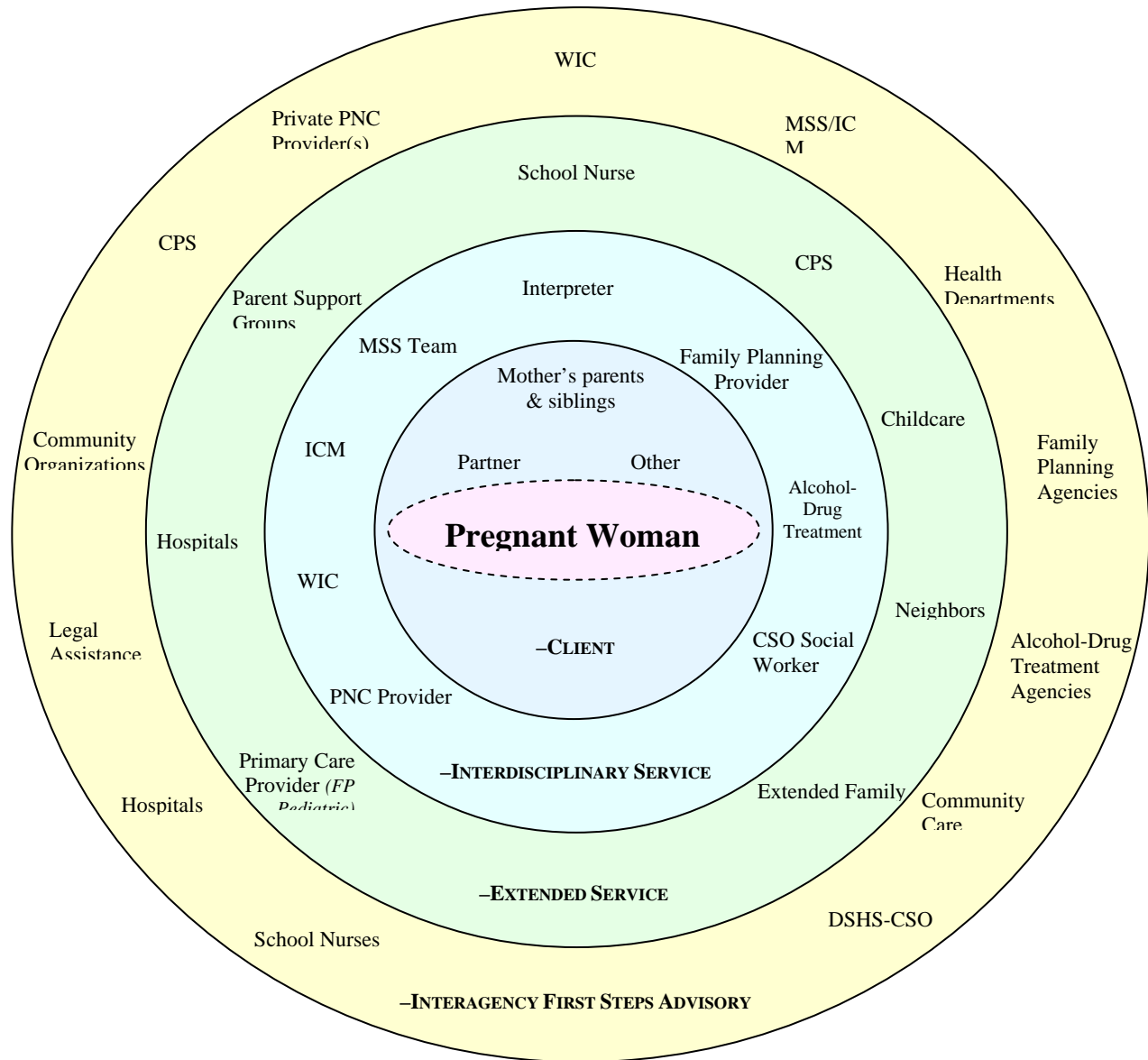
- The purpose, mission, or main objective is known and understood by all team members.
- Communication in the team is open, direct and honest.
- Sufficient leadership is available in the team.
- There is regular review of how well the team is performing toward achieving its goal.
- There is an agreed organizational structure to the team.
- Adequate resources are available to permit the team to perform its function, including skills, tools, facilities and budgets.
- Synergy exists, so the team performs in a way that is greater than the sum of its parts.

On-The-Job Actions of Successful Team Members

- Listen to understand
- Contribute ideas and solutions
- Recognize and respect differences in others
- Value ideas and contributions of all team members
- Participate fully and keep all commitments
- Be flexible and respect partnership created by team
- Have fun and care about team and outcomes

Interdisciplinary/Interagency Model of Care

This graphic illustrates the circle of service a First Steps client can participate in during the time MSS/ICM services are provided. Since linkage to systems is a critical part of the First Steps mission, the First Steps agency and its employees need to make contact with other service providers involved in the client's life.



Legend

WIC = Women, Infant and Children

MSS = Maternity Support Services

PNC = Prenatal Care

DSHS = Department of Social and Health Services

CPS = Child Protective Services

ICM = Infant Case Management

FP = Family Planning

CSO = Community Services Office

Adapted from model by National Training Center for Drug Exposed & HIV Infected Children and their Families. Roxbury, MA

Screening/Assessment

1. The focus of the screening is to aid the professional team members in identifying potential risk factors that may need further assessment and/or intervention, and determine the client's interests and priorities.
2. MSS staff must also screen women with older children for childcare needs for maternity related medical visits and authorize when needed. (See [Childcare Billing Instructions](#))
3. The process for completing/reviewing the screening tool, choosing which health messages and linkages to emphasize is a collaborative effort between the pregnant woman and one or more team members. This process is guided by the client needs and professional judgment.
4. Nonverbal communication, physical health signs as well as client verbal communication can assist in determining the client's ability to prioritize her needs.
5. At times more in depth assessment is needed for an identified risk factor to determine severity and determine appropriate interventions. An example is more in depth assessment for depression.

Basic Health Messages

There are many issues providers can discuss with clients during the maternity cycle. Listed below are basic health messages for all clients during MSS:

Maternity Cycle

- Importance of prenatal care and what to expect including information on HIV testing, Group B Strep, and TB screening
- Self care and coping, e.g. stress management
- Importance of support system
- Physical and psychological changes of pregnancy
- Nutrition, e.g. maternal nutrition, food insufficiency, and weight gain/loss
- Environmental dangers, e.g. hot tubs, lead poisoning, mercury, cat litter, gun safety, work hazards, seat belt use
- Physical activity in pregnancy
- Tobacco use and/or second hand smoke exposure
- Drug and/or alcohol use during pregnancy
- Oral health/prevention of dental disease
- Warning signs in pregnancy
- Breastfeeding

- Family Planning (Unintended Pregnancy Prevention)

Infant Related

- Baby Basics, e.g. sleep position (Back to Sleep), Shaken Baby Syndrome, Well-Child exams, immunizations, car seat safety, second hand smoke, care for minor illness, childcare choices
- Child Profile—health promotion materials the client should receive
- Bonding and attachment, e.g. eye contact, responsiveness, smiling and mirroring, normal child development
- Postpartum mood disorders, signs and symptoms and their impact on infant development
- Infant feedings

Advocacy, Linkage and Referral

The MSS period includes linkage, advocacy and referral services in addition to education, brief counseling and interventions. The goal of linkage during MSS/ICM is to address the client's current needs and develop a plan to improve the parents' self-sufficiency to access existing community resources. There is a sample [First Steps Resource List](#) for staff to complete, if desired, in [Appendix IV](#).

Advocacy

- Actions taken to support the parent(s) in accessing needed services or goods and helping the parent(s) to develop skills to access services.

Linkage

- Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.

Referral

- Providing information to the client that will assist them in receiving medical, social, educational, or other services.

Minimum referrals and linkages include:

- WIC
- Prenatal Care
- Pediatric Care
- Family Planning
- Childbirth Education
- Family Health Hotline toll free phone number and baby book, operated by WithinReach (formally Healthy Mothers Healthy Babies)

- Local community resources specific to individual needs, e.g. D.V. hotline, educational resources, Crisis Clinic, mental health resources, car seats, food bank, CPR training resources, childcare, transportation, interpreter services, disability services, and the tobacco quit line
- Parenting classes, moms and/or support groups
- Childcare

Risk Factors and Minimum Interventions

[MSS Minimum Interventions](#) define minimum standards for risk intervention over the course of service delivery.

Sixteen risk factors have been selected as the focus for Maternity Support Services. These risk factors are known to impact pregnancy and early parenting outcomes.

Professional judgment should be used to determine when to intervene and what interventions best match the client's needs and priorities.

Risk factors can be identified any time during the MSS period or the priorities of interventions for identified risk factors may change as the pregnancy progresses and a more trusting relationship is developed with the client.

For clients with more than one risk factor, interventions and service plan development will be discussed with MSS team members during the case conferencing process. Client participation in prioritizing needs should be included and documented on MSS Mother's Plan for Care.



Minimum Interventions: Remember minimal means just that—minimal. Staff is encouraged to provide additional services related to the identified risk factors as resources allow.

Health information regarding risks will be provided to the woman in a non-confrontational manner, to help her understand the immediacy of need to change behavior or seek services.

MSS #1: Late Entry, Intermittent or No Prenatal Care**Evaluate:**

- Note any known history and the client's verbal and non-verbal cues for alcohol/substance use, domestic violence, developmental disabilities, mental health symptoms and any other signs of distress.
- Explore barriers to participation in prenatal care, such as lack of transportation, reluctance to be involved with government programs, language barriers, cultural and/or religious differences, frequent moves, unaware of pregnancy, fear of CPS, or legal involvement, minimal or punitive support system, or conflict with health care provider.

Inform:

- Tell the client about the importance of early prenatal care.
- Provide a list of Healthy Options prenatal care providers, or other fee-for-service prenatal care providers.
- For the post-partum client on Medicaid, describe/offer Maternity Support Services. Screen, and if eligible, offer Infant Case Management. Provide a list of pediatric care providers.

Act:

- Document risk factor on care plan.
- Address the client's identified issues, using interventions for identified risk factors, such as alcohol/substance use, domestic violence.
- Problem-solve with client the barriers to initiating or participating in regular prenatal care.
- For the postpartum client, explore barriers to follow up care, family planning services and pediatric health care.
- Refer to WIC if not already involved.
- Case Conference with team members.

Ongoing Follow-up and Outcome:

- Determine if medical care is established and continue to review barriers, if any.
- Enroll the infant in Infant Case Management services if risk factors are not significantly ameliorated by two months postpartum.
- Monitor infant and mother for negative pregnancy related and birth outcomes.
- Document outcomes on the care plan, and if no changes occurred since the risk factor was identified, describe why.

MSS #2: Brief Interventions for Adjustment to Pregnancy**Evaluate:**

- Evaluate the client's feelings and thoughts about the current pregnancy, including timing/planning, and the involvement of the baby's father.
- Determine the adequacy and effectiveness of current support system.
- Explore options the client has considered, if any.
- Evaluate the client's current plans for this pregnancy.
- Who is available to the client for discussion about the pregnancy?
- Explore the client's awareness regarding the impact pregnancy and parenting may have on her life (e.g. relationships, work, school, her body, finances).

Inform:

- Inform the client about the availability of options and counseling, if desired.
- Normalize the mixed emotions associated with initial awareness of a pregnancy.
- Provide relevant information on the issues.

Act:

- Document risk factor on plan for care.
- Refer if applicable, to local community resources (e.g. WIC, support groups).
- Provide unconditional emotional support to client as she processes her feelings and makes a decision to parent or not.
- Refer to MSS Behavioral Health Specialist and/or case conference with team members.

Ongoing Follow-up and Outcomes:

- Revise the plan for care, as needed, with the client.
- Conduct additional interventions based on discussion with interdisciplinary team.
- Follow-up with the client on current feelings and plans throughout the pregnancy.
- Explore the outcome of referrals made to community resources.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #3: Food Insufficiency**Evaluate:**

- Assess urgency of issue and client's awareness of community resources for food or other necessities. Has the client used a food bank? Is the client eligible for Food Stamps and if so, has she applied? Is she enrolled in WIC?
- Where does the client eat most of her meals?
- Who prepares her meals and snacks? What does she prepare for herself?
- What equipment is available for cooking?
- Is lack of knowledge or skill in food preparation, budgeting, and meal planning a factor?
- What is available for food storage? Refrigerator? Containers?
- Are containers "raid-proof" from vermin?
- Are there barriers to resources—transportation, cultural issues, and the client's beliefs around using resources?

Inform:

- Share information on local food resources in the community.
- Review options for food storage or preparation issues.
- Introduce local resources to decrease or lessen barriers such as transportation.

Act:

- Document risk factor on plan for care.
- Ask MSS registered dietitian to work with her on developing cooking skills and food budgeting.
- Refer to community resources for emergency food, if needed.
- Explore and help to identify opportunities for cooking and storing food on a temporary basis.
- If housing is an issue, explore other housing options.
- Work with the client on ways to decrease barriers to access and storage of food.
- Case Conference with team members.

Ongoing Follow-up and Outcomes:

- Determine adequacy of food resources, cooking equipment and storage.
- Identify changes in the client's knowledge of budgeting and cooking.

- Follow-up on barriers to food access.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS # 4: Skipped Meals

Evaluate:

- Rule out Food Insufficiency as cause.
- Determine what sort of social support is acceptable to the client and is needed.
- Ascertain how frequently skipped meals occur.
- Determine if skipped meals are in relation to concerns around weight gain. Discuss client's expectations regarding pregnancy and weight gain.
- If weight, body image, or restrictive eating is a clear concern, assess for an eating disorder.
- If a past eating disorder is revealed, review her history with this disorder and whether she has had any medical or other treatment.
- Identify barriers to food intake, e.g. hectic schedule, lack of social support, and/or issues around nausea and vomiting.

Inform:

- Discuss how skipping meals can impact nutrition status and pregnancy.
- If weight gain is an issue, offer information on normal weight gain patterns and client's concerns.
- Encourage the importance of prenatal multi-vitamin and mineral supplements, but discourage their use as a replacement for eating.
- If an eating disorder is known, discuss her current status and knowledge of impact on pregnancy.

Act:

- Document risk factor on plan for care.
- If food insufficiency is an issue, refer to [Risk factor #3, Food Insufficiency](#).
- Refer to MSS registered dietitian.
- If the client regularly skips meals, then problem solve with the client to try and add one meal or snack to her schedule to reduce fasting time to less than 10 hours.
- If the client has a documented eating disorder (anorexia nervosa, bulimia), or there may be an eating disorder, refer to counseling.
- With ongoing eating disorders consult with a specialist in this area for continued care, if not already established.
- Case Conference with team members.

Ongoing Follow-up and Outcomes:

- Follow up and work with the client to resolve barriers to eating regular meals.
- Document if an eating disorder exists and refer to services outside MSS.
- Consider for Infant Case Management.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS#5: Medical Conditions**Evaluate:**

- Review the client's health history (e.g. hypertension, diabetes, premature delivery).
- Observe and record any negative physical health symptoms or client complaints discovered or discussed during a visit.
- Determine the current status of the medical condition/symptoms and management by the obstetrical care provider.
- Review and record any treatment prescribed or self-administered to decrease symptoms and/or prevent complications during the maternity cycle.
- Explore the client's understanding of the medical condition/symptoms, treatment and the potential effects it may have on pregnancy health and infant outcomes.

Inform:

- Share preventive health information and self-care methods that may enhance the woman's ability to cope with the condition/symptoms and follow any prescribed treatment regimes.
- Review basic health care messages including "danger signs" during pregnancy.

Act:

- Document risk factor on plan for care.
- Refer to MSS Nurse regarding any emergent or increasing symptoms of physical distress or discomfort.
- Consult with the obstetrical care provider regarding emergent symptoms and/or emergency room when symptoms require immediate intervention.
- Refer to the MSS Registered Dietitian for evaluation of diet in relation to medical issues (e.g. diabetes, hypertension, anemia, bariatric surgery, Crohn's, and/or bed-rest)
- Case conference and develop a plan with interdisciplinary team when medical conditions are complex, infectious or chronic.
- Determine a lead worker for complex medical issues, based on the client's needs, team members' knowledge of the condition, and relationship with the client.

Ongoing Follow-up and Outcomes:

- Continue to follow issues as needed and make referrals.
- Document any communications with medical providers.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #6: Mental Health (MH) Concerns**Evaluate:**

- Identify changes in appetite, speech patterns, sleep, and mood congruence that may be symptoms of MH concerns.
- Observe/discuss ability to perform daily activities such as meal preparation, grooming, hygiene, eating, and post pregnancy ability to care for infant and recognize/respond to infant's cues.
- Explore adequacy of client's support system and coping skills.
- Inquire about involvement in MH services and/or past history of treatment.
- Assess the client's awareness of her behavior, symptoms, and willingness to address them.
- Determine the client's awareness of the impact mental health issues can have on pregnancy and parenting the newborn.
- Assess emergent safety issues such as harm to self or others.

Inform:

- Provide information regarding the effects of mental health /emotional well being on physical health and pregnancy.
- Stress the importance of a support system.
- Provide resource information and appropriate linkages, including referral to Behavioral Health Specialist on the MSS team.

Act:

- Document risk factor on plan for care.
- Refer to the MSS Behavioral Health Specialist.
- If client is involved in MH Services, obtain a release and coordinate with MH provider.
- Administer a depression screening tool, if applicable.
- Obtain permission and collaborate with medical provider.
- Assess safety risks for client and/or others and contact CPS and/or county designated mental health professional as indicated.
- Case conference with interdisciplinary team.

Follow-up and Outcomes:

- Follow-up on the client receiving services/referrals and advocate on client's behalf, if needed.

- Document outcomes on the plan for care and if no change occurred since the risk factor was identified, note why.
- Additional considerations for mood disorders:
 - Administer a depression screening tool when entering care and each trimester thereafter, including two months post pregnancy.
 - Emphasize the importance of light, exercise, and proper nutrition in improving mood.

MSS #7: Developmental Disabilities/Cognitive Impairment**Evaluate:**

- Determine the client's current level of functioning related to activities of daily living, such as dressing, hygiene, meal preparation, and money management.
- Inquire about the client's current support systems/resources.
- Begin to assess the client's problem-solving abilities and ability to utilize available resources.

Inform:

- Inform the client of community resources and how to access them.
- Emphasize the importance of having resources to help meet the challenges client may face in pregnancy and parenthood.

Act:

- Document risk factor on plan for care.
- Obtain consent and contact the client's other care providers/support people to coordinate care and determine their capacity to serve the client.
- Include community resources, medical staff, and entire MSS team in developing a plan for care that incorporates instructional methods suitable to client and ongoing monitoring and communication among community team members.
- Contact local DSHS Children's Administration and/or local Adult Protective Services if safety for self or others is a concern.
- Refer the client to Division of Developmental Disabilities if not already connected and if the impairment occurred before age 18.

Ongoing Follow-up and Outcomes:

- Coordinate services with other providers and evaluate progress.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #8: Inadequate Social Support**Evaluate:**

- Ask open-ended questions to further explore social support questions, such as: How available/close are your family/friends? How often do you talk to family members/friends? How long have you lived in the community? Do you have someone who could take you to the hospital in case of an emergency?
- Evaluate barriers to support system such as no phone, lack of transportation, or language issues.

Inform:

- Provide information regarding the importance of social support during pregnancy and parenting.

Act:

- Document risk factor on plan for care.
- Ask client about her priorities and interests in linking with individuals or groups such as WIC, Head Start, moms' groups, CBE classes, parenting classes, AL-ANON, church groups.
- Problem solve if transportation/phone are barriers to accessing support.
- Case conference with other team members when social support is minimal.
- Refer and support the client in accessing the services of professionals who are skilled in helping others build personal and community relationships.

Follow-up and Outcomes:

- Screen for possible changes in social support throughout pregnancy. Readjust intervention plan as needed.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #9: History of/or Current CPS Involvement**Evaluate:**

- Identify when and where (county and state) client was involved with CPS and name of caseworker.
- Obtain client's perception of why CPS is involved.
- Determine if client understands the status of her case; what activities she is involved in and her current level of involvement in these activities.
- Determine client's motivation to change.
- Identify available support: is it adequate and appropriate?

Inform:

- Inform the client of available resources and make referrals.
- Talk about impact of CPS, or history of CPS, on her pregnancy/child.

Act:

- Document risk factor on plan for care.
- With client's permission, contact CPS caseworker to coordinate activities and interventions to assist client in parenting successfully.
- Refer to the MSS Behavioral Health Specialist regarding emotional support for client in dealing with the grief and loss issues around the placement of her child(ren).
- Case Conference with team members.

Ongoing Follow-up and Outcomes:

- Follow-up with client about activities related to the MSS Plan for Care and CPS plan.
- As delivery approaches, re-assess client and infant safety, confer with team as needed.
- Follow-up with CPS, notifying them of termination of services and/or change in focus when infant is two months of age.
- Screen for Infant Case Management program eligibility.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #10: Maternal Grief and Loss**Evaluate:**

- Determine source of loss, i.e. previous or current pregnancy, loss of child, partner, or other loved one.
- Assess client's perception of current coping and understanding of grief/loss process.
- Assess current coping skills and their effectiveness.
- Identify available support and whether it is adequate.

Inform:

- Provide relevant information on issues of grief and loss.
- Normalize current emotional responses and feelings while providing information on self-care during the grief process.

Act:

- Document risk factor on plan for care.
- Refer and consult with the Behavioral Health Specialist and other team members regarding additional interventions.
- Refer to available community support groups and resources.
- Develop plan for care with client and team to best meet the client's needs and reduce risks.
- Provide additional interventions according to the expertise of the interdisciplinary team.

Ongoing Follow-up and Outcomes:

- Continue to monitor client's status and modify interventions as needed.
- At the end of the maternity cycle provide client with additional resources for ongoing follow-up and services in the local community.
- Screen for Infant Case Management program eligibility
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #11: Domestic Violence Situation**Evaluate:**

- Create a safe and private setting for client screening, without possible abuser present.
- Determine immediate safety issues.
- Evaluate for additional signs and/or symptoms of physical, sexual and/or emotional abuse.
- Evaluate knowledge and utilization of available resources/support.
- Discuss the client's goal and willingness to take additional action.

Inform:

- Define domestic violence—verbal as well as physical abuse.
- Provide information and linkages to available resources.
- Discuss increased risks and potential harm of violence during pregnancy.
- Give information about safety planning.

Act:

- Document risk factor on plan for care.
- Refer to MSS Behavioral Health Specialist.
- If the client refuses services at this time, make sure she knows how to access services at a later date.
- If the client is willing, assist her to connect with local DV resources
- Develop a safety plan with team members prior to home visits.
- Do NOT recommend couple's counseling or anger management classes.
- Case Conference with team members.

Ongoing Follow-up and Outcomes:

- Develop plan for care with the client and team members.
- Implement additional interventions according to the expertise of the interdisciplinary team.
- Provide support and assistance to client in achieving her stated goals.
- Provide information about domestic violence, risks and impact on children.
- If not eligible for Infant Case Management after the two months post pregnancy visit, provide community resources for additional follow-up and support.

- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #12: Tobacco Use and Secondhand Smoke Cessation/Reduction (Performance Measure*)

Address tobacco usage and second hand smoke exposure as a brief part of every visit.

Evaluate:

- Ask the client about her past and current tobacco use.
- Ask the client about her current exposure to secondhand smoke, and about the environment(s) where the baby will be.
- Evaluate her readiness to change by using the Stages of Change scale below:

Stages of Change	
Not Ready to Quit	Has no intention to quit within the next six months. These clients may be uninformed of the dangers of tobacco. They may use tobacco as a coping mechanism. They may be unprepared or willing to deal with nicotine withdrawal symptoms. They may have been trying to quit, been unsuccessful and unwilling to try again at this time.
Thinking about Quitting	Intends to quit within the next six months. These clients have reasons to quit and reasons to keep smoking. They are aware of risks associated with their tobacco use, but are not ready to make a commitment to quit.
Ready to Quit	Is willing to set a Quit Date within the next 30 days.
Quitting	Has remained tobacco-free for less than six months.
Staying Quit	Has remained tobacco-free for more than six months. These clients have already quit and are learning to live without tobacco. During this stage, relapse is still a danger.
Relapse	Is using tobacco again after a period of being tobacco-free. Relapse is common, especially among postpartum women: 79–90% return to smoking within one year after delivery. Women often relapse due to multiple stressors as they return to former activities and familiar coping methods.

Inform:

- The use of tobacco education posters, tabletop signs, and other visible messages creates an environment that makes asking about tobacco use a normal and expected part of an office visit.
- If the woman is a pregnant/postpartum smoker, provide additional information tailored to her, including the American Cancer Society's magazines and *Make Yours A Fresh Start Family* brochure.
- Depending upon her stage of change, offer the appropriate information, messages, handouts, and assistance.
 - Example for a client contemplating change: "As your provider, I need you to know that quitting smoking is the most important thing you can do to protect the health of your unborn baby. If you are thinking of quitting at this time, I can help you get started."
- Depending upon her situation, offer information about ways to eliminate secondhand smoke exposure and offer assistance that will support changes.
 - Example: "It is OK to encourage people to smoke outdoors, which is a good way to protect you and your baby from secondhand smoke".

Act:

- Document risk factor on plan for care.
- Determine the client's willingness to make a quit attempt at the present time (for example, within the next 30 days).
- If the person is willing to make a quit attempt, provide assistance setting a Quit Date.
- If the person clearly states an unwillingness to make a quit attempt at the present time, offer support and appropriate information to get the person thinking about quitting.
- Document client specific information on tobacco use, secondhand smoke exposure, and assistance provided and record progress and outcomes in the client's chart, as required in the Tobacco Cessation During Pregnancy Performance Measure.
- Case Conference with team members.

Ongoing Follow-up and Outcomes:

- Follow-up may be as simple as an invitation to talk about quitting in the future. Or follow-up may be arranged for a specific time, such as when a pregnant woman returns for an appointment, or when the provider returns for a home visit.
- It is particularly important to arrange follow-up contact with a tobacco user who is making a quit attempt. Whenever possible, arrange the follow-up within a week after the individual's Quit Date. During the follow-up contact:

- Ask about tobacco status.
- Congratulate individuals who are tobacco-free and support them in staying quit.
- Support people who have relapsed and help them in making a new quit attempt.
- Develop with the client a post-pregnancy plan addressing the following:
 - How to remain tobacco free, or
 - How to continue to reduce tobacco use.
 - Keeping the newborn free from exposure to secondhand smoke.
 - Support systems that are available to the client; e.g. Medical referral, Community resources, Washington State Quit line, Secondhand smoke materials, WIC, other.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

*This risk factor is one of the performance measures. Billing is allowed for completing the information for this risk factor when recording outcomes on the discharge summary. Additional information is available in the MSS/ICM Billing Instructions.

MSS #13: Alcohol and Substance Use Prior to and During Pregnancy**Evaluate:**

- Note any pertinent history and client's verbal and non-verbal behavior suggesting alcohol/substance use.
- Assess the client's motivation to change substance use behavior including: frequency and type of use, client's concern regarding use, knowledge of the effects of substance use during pregnancy and stage of change regarding abstinence. [*Stages of Change*](#) are listed under MSS Risk Factor #12, Tobacco Use.

Inform:

- Offer health messages regarding substance use during pregnancy.
- Provide harm reduction health messages if client is unable to achieve abstinence during pregnancy.

Act:

- Document risk factor on plan for care.
- Support the client in her change process including: listening to understand her experience; problem solving together to reduce barriers to change; supporting and reinforcing her sense of self-efficacy to make changes to achieve harm reduction or abstinence.
- Refer client to DASA for expedited assessment. If it is determined treatment is needed, the pregnant client has priority for available services.
<http://www1.dshs.wa.gov/pdf/hrsa/dasa/PregnantWomenGuide.pdf>
- Provide information and/or refer to chemical dependency resources including assessment, treatment, and referrals to Narcotics Anonymous (NA) or Alcoholics Anonymous (AA), etc.
- Inform the client that for a healthy birth outcome the provider must be notified.
- Alert CPS and hospital (in the third trimester) if use continues throughout pregnancy and inform the client of this action.
- Case conference with MSS team members.
- Determine whether there is alcohol/substance use in the environment (partner, parent, grandparent, support person).
- Support the client in developing a safety plan for herself and her children if needed.
- Refer the client to a support program such as Al-Anon.
- Assess basic needs such as food and housing. Refer, link and advocate on client's behalf.

Ongoing follow- up and Outcomes:

- Observe the client and environment for signs of use at each encounter.
- Reassess the client periodically in pregnancy and post-pregnancy period for [*Stages of Change*](#) progress and if abstinent, ability to maintain.
- Support problem solving and reinforcing self-efficacy throughout.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #14: Coping and Stress**Evaluate:**

- Explore with client the risks (stressors) she has identified on the screening tool and how they challenge her coping abilities in daily living, caring for herself and/or planning for the future.
- Explore with client her physical and mental responses to stressors. Examples: anger, stomach distress, anxiety, sleeplessness.
- Explore with client the coping mechanisms (healthy and unhealthy behaviors) she uses to deal with the symptoms of stress. Examples: daily exercise, calling or visiting supportive people, smoking, overeating.

Inform:

- Ask the client what she knows about the possible effects of stress on pregnancy.
- Share additional information such as the benefits of exercise, sunlight, and good nutrition in dealing with stress and improved coping.

Act:

- Document risk factor on plan for care.
- Assess client's stage of change regarding readiness to develop new or improved coping mechanisms. Adapt the intervention to client's current stage according to the [*Stages of Change*](#).
- Case conference with other team members. Include client input in developing plan to improve one or more coping skills. Include harm reduction methods for women who use coping mechanisms that are destructive such as smoking, drugs or alcohol use, bingeing, purging, and/or gambling.
- Refer to appropriate community resources.
- Provide written materials if desired by client.
- Refer to the MSS Behavioral Health Specialist.
- Case Conference with team members.

Ongoing Follow-up and Outcomes:

- Continue to consult with Behavioral Health Specialist if the client is not currently being seen or minimal progress is made in developing or modifying coping skills.
- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS #15: Unintended Pregnancy Family Planning (Performance Measure*)**Evaluate:**

- Initiate a discussion about post pregnancy family planning with the client (and her partner if possible), including the desire for another pregnancy and options for family planning (FP) until that time. The FP Interview Guide can assist in this discussion.
- Determine the client's (and the partner's) understanding of currently available birth control methods, how they work, their efficacy, and potential side effects.
- Determine barriers to using birth control by reviewing prior birth control use and plans for future pregnancies.

Inform:

- Review family planning options available through Medicaid. Include in the discussion the extended benefits for FP services through one year post pregnancy.
- Review and provide resources for FP services such as the current Medical care provider, CSO nurse, pharmacies, and Planned Parenthood agencies, and local TAKE CHARGE programs.
- If the client is breastfeeding, or planning to breastfeeding, discuss options and needs around FP.

Act:

- Document risk factor on plan for care.
- Show and describe current FP Methods available using the FP Performance Measure as a guide. Use a FP “tool box” for demonstration. Update or develop a “tool box” by soliciting outdated materials from FP care providers in the community.
- Use [*Stages of Change*](#) theory and Motivational Interviewing to help the client (couple) explore why consistent use of a birth control method has been a problem in the past or may be a problem in the future.
- Refer a male partner to a TAKE CHARGE program if he considers or desires a vasectomy and qualifies for services.
- Advise the client to discuss her desire for tubal ligation or Depo Provera with her medical care provider prior to labor and delivery.
- Complete Family Planning Performance Measure within 60 days post pregnancy.

Ongoing Follow-up and Outcomes:

- Explore barriers to initiating birth control methods. Refer, link and advocate if applicable to services such as the CSO nurse or FP clinic.
- Refer to CSO nurse, if no FP decisions have been made.

- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

*This risk factor is one of the performance measures. Billing is allowed for completing the information for this risk factor when recording outcomes on the discharge summary. Additional information is available in the MSS/ICM Billing Instructions.

MSS #16: History of Sexual, Physical and Emotional Abuse**Evaluate:**

- Review current maltreatment questions in which the client may reveal a history of sexual, physical and/or emotional abuse.
- Screen all women for domestic violence and substance abuse once a trimester and in the post-pregnancy period.
- Note physical symptoms and communication patterns during screening that may indicate client discomfort, anxiety or fear.
- Assess coping mechanisms.

Inform:

- Inform the client about resources for clients who disclose abuse so they can access resources when ready.
- Inform the MSS client of behavioral health services in MSS and promote connection, if she is not currently receiving these services.
- Provide basic health messages/linkages with specific attention to areas of concern to the client, such as fears related to delivery, parenting, and breast-feeding.

Act:

- Document risk factor on plan for care
- Build trust through client centered interviewing, provided in a respectful, non-obtrusive manner.
- Develop a plan for care collaboratively with the client and interdisciplinary team.
- Refer client to childbirth and parenting education classes, if desired, encouraging partner participation if relationship is supportive.
- Advocate and support the client in accessing counseling services when she is ready.
- Screen for depression during pregnancy and in post-pregnancy period.
- Facilitate discussion between the client and her medical care provider about fears she may have about labor, delivery and newborn care.

Ongoing Follow-up and Outcomes:

- Reassess and document the client's coping mechanisms, symptoms of distress throughout pregnancy and the post-pregnancy period.
- Screen for Infant Case Management eligibility and if qualified, offer services.

- Document outcomes on the plan for care, and if no change occurred since the risk factor was identified, note why.

MSS Case Conferencing

Case conferencing reduces the duplication of services and allows for a coordinated service delivery system that utilizes the allowable units in the most efficient and productive manner. Interdisciplinary case conferencing is expected during the maternity cycle. The frequency of interdisciplinary case conferencing for any MSS client is based on client need, client risk factors, and whether or not more than one agency is involved in the client's care. If a client has one or more of the sixteen risk factors identified in the core services, then case conferencing is required.

The case conference may take place in a variety of ways: through regularly scheduled team conferences, informal face-to-face discussion among two or more team members, by phone, or by written communication. The case conference must be documented in the primary client record specifying the date, who attended, and a brief discussion of issues. The plan for care will be modified based on the case conference decisions and includes the issues, intended interventions, and outcomes.

Infant Case Management

Infant Case Management (ICM), a part of the First Steps program, serves high-risk infants and their biological parents. The infant/parent(s) who meet high-risk criteria must also need help in accessing resources to meet their needs. The goal of ICM is to improve the parents' self-sufficiency in gaining access to needed medical, social, educational, and other services.

The WAC definition of case management is: services to assist individuals who are eligible under the Medicaid state plan to gain access to needed medical, social, educational or other services.

Visit the website to obtain a copy of the Maternity Support Services and Infant Case Management Billing Instructions. The current reimbursement fee schedule is also on the First Steps website: <http://fortress.wa.gov/dshs/maa/firststeps>

Core Functions of the Infant Case Manager

The core functions of the Infant Case Manager are to provide or assist in providing:

- Screening
 - Activities that focus on needs identification for any medical, educational, social, and/or other services for infants, biological parents and their families.
- Care Planning
 - Building on the information collected through the screening process, this activity ensures client participation to develop goals and identify a course of action to respond to the identified needs.
- ICM Actions
 - Advocacy: actions taken to support the biological parent(s) in accessing needed services or goods and helping the biological parent to develop skills to access services.

- Linkages: Networking/collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.
- Referral: Providing information to the client that will assist them in receiving medical, social, educational, or other services.
- Monitoring/Follow Up
 - Activities and contacts necessary to ensure the plan for care is effectively implemented, adequately addressing the needs of the Medicaid eligible individuals.

ICM Actions and Plan for Care

There are three major actions noted on the plan for care: referrals, linkages, and advocacy. Actions suitable for ICM interventions include:

- Reinforcing the importance of self-care and coping, social support systems.
- Exploring environmental dangers such as tobacco use or secondhand smoke.
- Reinforcing “baby basics” and infant health messages such as:
 - Oral health
 - Bonding and attachment with infant
 - Normal infant development
 - Breastfeeding
 - Immunizations
 - SIDS/Safe Sleeping
 - Shaken baby syndrome
 - Car seat safety
 - Care for minor illnesses
 - Child care choices

Infant Case Management Case Conference Requirement

There is no overall requirement for Infant Case Management clients to have interdisciplinary case conferences. Infant case management is not an interdisciplinary model of service. The Infant Case Manager is a generalist, who advocates, links and refers infant and family to appropriate community health and social services.

In specific cases, however, the need may arise to have an intra-agency case conference or an interagency case conference. There are times when infant case managers bring specific cases to their supervisor(s) for additional input or advice. In some instances the supervisor may suggest the infant case manager discuss the case with the Maternity Support Services or First Steps team as an intra-agency case conference. Since the infant case manager’s duties include advocacy and linkage, there may be other occasions where the infant case manager initiates a meeting or

telephone conference call with other agency service providers to ensure care continuity for a specific infant and family.

Infant Case Manager Checklist

This document can be used as a Microsoft Word-based form. The file needs to be protected to access the form (Tools> Protect Document...: no password). To answer the questions, click in the appropriate shaded checkbox(es) or click in the shaded blank fields and type in textual information.

The pages can also be printed and used as a paper-based form.

Have I assessed the following needs, taking into consideration available community resources?

Basic Needs

- ☐ Housing (living in homeless shelter, car, tent or motel)
- ☐ Space for infant, baby supplies, clothing
- ☐ Adequate food supply (Food Stamps, food bank, WIC)
- ☐ Cooking facilities, refrigeration, assistance with utilities, heat, hot water, telephone, toilet, bath/shower
- ☐ Income (assistance with employment, job skills training, job readiness programs, vocational education, GED completion, public assistance/TANF grant, application for social security benefits/SSI)

Medical Needs:

- ☐ Medical coverage for each family member
- ☐ Primary care medical provider for each family member
- ☐ STDs and/or HIV/AIDS testing and counseling
- ☐ Baby is linked to a pediatrician/well child check ups
- ☐ Infant or other child in the home has special health care needs
- ☐ Immunization schedule
- ☐ Tobacco cessation counseling

Local Needs:

- ☐ Access to transportation
- ☐ Plans to work before the baby is a year old
- ☐ Reliable Childcare
- ☐ Knows how to screen a childcare provider

Adjustment to Parenting

- ☐ Bonding and attachment
- ☐ Coping and Stress
- ☐ Parenting education/classes

☐ Appropriate Discipline

Mental Health Needs:

- ☐ Postpartum mood disorders (signs, symptoms)
- ☐ Mental health needs (inform primary care physician)
- ☐ Chemical dependency assessment/treatment
- ☐ Eating disorder counseling

Family Planning:

- ☐ Family planning resources/access to a birth control method
- ☐ Family wants information on [open] adoption

Other Issues

Ancillary Services

This section of the manual covers additional First Steps services, including childcare, childbirth education, transportation, interpreter services, and other resources.

First Steps Childcare Program

The First Steps Childcare program funds childcare so pregnant women can access prenatal care or other DSHS-covered medical services when no other childcare resources are available. All First Steps clients will be screened for childcare needs

Authorization and Eligibility for Childcare

Childcare must be authorized by an MSS staff person. Once authorized, qualified childcare providers are reimbursed on an hourly basis per child. (See *First Steps Childcare Billing Instructions*) Childcare can be authorized during the maternity cycle (pregnancy through two months post-pregnancy).

Eligible Childcare Providers

The program can pay licensed childcare providers, friends, and some other family members. Due to federal restrictions, grandparents of the new baby cannot be paid for this childcare. Details of who is eligible to be paid for child care are in the *First Steps Childcare Billing Instructions*.

Background Check

All unlicensed childcare providers must pass a Background Check. Complete details on this process are in the *First Steps Childcare Billing Instructions*.

Reasons for Childcare Authorization

Bed-rest

The bulk of First Steps childcare is paid when women are ordered to bed-rest by a medical provider. Prior authorization by DSHS is required for childcare when a woman is on bed-rest so it is important to verify with the provider the reason for the bed-rest (some will give a written note indicating this) and document it in the client's chart. A list of possible reasons for bed-rest is listed in the *First Steps Childcare Billing Instructions*. If the client is ordered to bed-rest for other reasons, please document it and fax a copy to the First Steps Childcare Program Coordinator. (See [First Steps State Contacts in Appendix III.](#)) DSHS staff will review and fax a response.

Labor or Delivery

When a woman is in labor or is delivering, First Steps Childcare will pay for three days of childcare for a vaginal delivery and five days for a C-Section. The mother does not have to be in the hospital for the children to receive care.

Hospitalization of Newborn

First Steps Childcare can also be paid when a newborn is hospitalized, either in the Neonatal Intensive Care Unit (NICU) or elsewhere and this also requires prior authorization by DSHS. The authorization process is described in detail in the *First Steps Childcare Billing Instructions* (see the link below).

Details and Questions

For complete details about when prior authorization by DSHS is required, refer to the *First Steps Childcare Billing Instructions*, and required forms can be found at:

<http://fortress.wa.gov/dshs/maa/download/BillingInstructions/FSCC%20BI%2011-15-04.pdf>

If there are questions about authorization in a particular case, please call the First Steps Childcare Program Coordinator. (See [First Steps State Contacts in Appendix III](#).)

Childbirth Education (CBE) Classes

Childbirth education classes are an ancillary service that should be offered to all Medicaid eligible women.

The purpose of childbirth education is to help prepare the client and her support person(s) to:

- Understand the physiological, emotional and psychological changes the client is experiencing.
- Develop self advocacy skills.
- Understand what to anticipate prior to, during, and after labor and delivery.
- Understand and plan for the changes that occur post-pregnancy.
- Increase positive relationships with local community resources.
- Understand positive and basic parenting skills.

Instruction is to be delivered in a group setting and must be completed over several sessions.

Eligibility for Childbirth Education

To be eligible for childbirth education [WAC 388-539-0390(2)], a client must:

- Be pregnant
- Present a DSHS Medical Identification (ID) card with one of the identifiers from the box below:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP—CHIP	Categorically Needy Program—

	Children's Health Insurance Program
CNP—Emergency Medical Only	Categorically Needy Program- Emergency Medical Only



If the client is pregnant, but her card does not list one of the above medical program identifiers, please refer her to the local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

Clients who are enrolled in a HRSA managed care plan are eligible for childbirth education outside their plan. HRSA reimburses for childbirth education through its fee-for-service system. Coverage and billing guidelines found in these billing instructions apply to managed-care clients. Clients who are enrolled in a HRSA managed care plan will have an “HMO” identifier in the HMO column on their DSHS Medical ID cards.



A CBE client is not required to be enrolled in MSS/ICM in order to qualify for CBE covered services.

CBE Providers

The Department of Health (DOH) and the Department of Social and Health Services (DSHS) work in cooperation to make this possible. All agencies and/or individuals that choose to offer CBE in a group setting need to apply and must meet required CBE assurances in order to be assigned a provider billing number and receive reimbursement. Reimbursement is limited to one series per client, per pregnancy. Details for billing Childbirth Education classes may be found in the *Childbirth Education Billing Instructions* at:

<http://fortress.wa.gov/dshs/maa/download/BillingInstructions/>

Any childbirth education that is provided by an approved MSS/ICM provider during a one-to-one home or office visit is to be billed as part of MSS services (within the 60 unit maximum).

The First Steps Childbirth Education Consultant can be reached by calling 360-236-3552.

Childbirth Education Provider's Application

[WAC 388-539-0390(3)]

All agencies and/or individuals that choose to offer CBE in a group setting must apply for a separate CBE provider number and meet the required CBE assurances in order to be reimbursed.

All childbirth educators providing services under this billing instruction must:

1. Be an approved childbirth education (CBE) provider with an assigned CBE number.
2. Have a signed Core Provider Agreement on file with HRSA.
3. Deliver CBE services in group sessions.
4. Bill the HRSA according to these billing instructions.

Childbirth Educators and/or agencies must complete the HRSA Core Provider Agreement prior to billing. Upon approval, HRSA will assign a provider billing number.

For CBE billing information, please refer to the CBE Billing Instructions.



HRSA considers services provided and billed by staff not qualified to provide those services as erroneous billings and will recoup any resulting overpayment during an audit.

Call the Department of Health at (360) 236-3552 for a CBE Provider Application packet that details a Childbirth Educator's Required Qualifications or request information from:

DOH—Maternal and Infant Health
Health Education Consultant
PO Box 47880
Olympia, WA 98504-7880

Childbirth Education Services

What is covered

HRSA covers one series of childbirth education classes per eligible client, per pregnancy. Childbirth education classes must be delivered in group sessions by providers approved by DOH program consultants. Reimbursement for childbirth education classes includes all classes and educational materials provided throughout the session. [WAC 388-539-0390(4)]

A client must attend at least one CBE session in order for the provider to be reimbursed for the CBE services to the client. [WAC 388-539-0390(7)(b)]

What is not covered

Under the Childbirth Education Program, HRSA does not cover childbirth education that is provided during a one-to-one home or office visit. [WAC 388-539-0390(5)]

For information regarding one-to-one home or office visits, refer to the Maternity Support Services and Infant Case Management Billing Instructions, dated October 2003. To view or download this manual, go to: <http://maa.dshs.wa.gov> (select Billing Instructions/Numbered Memoranda).

Required Topics Covered in Childbirth Education Classes**Pregnancy Topics**

- Prenatal Care
- Appropriate pregnancy exercises and their benefits
- Coping with common discomforts of pregnancy
- Danger signs in pregnancy and what to do
- Environmental hazards (including but not limited to alcohol use; tobacco use, secondhand smoke exposure, mercury, toxoplasmosis, listeriosis)
- Nutritional needs of mother and fetus
- Physical and Emotional changes during pregnancy
- Sexuality during pregnancy, (including safe sex education)
- Preparing to breastfeed
- Planning for a future pregnancy

Labor and Birth Topics

- Informed consent and decision making
- The value and role of labor support persons (Doula, partner, friend, relative)
- Signs and symptoms of true vs. false labor
- Warning signs and what to do
- Coping skills for each stage and phase of labor
- Pain management techniques and options
- Minimizing and/or working with labor complications
- Medical procedures and interventions
- Analgesia and anesthesia options
- Types of deliveries (benefits and drawbacks of each)

- Unexpected outcomes and what to do
- Hospital routines, including a tour of a hospital/birthing center

Newborn Topics

- Newborn procedures standard in Washington State (APGAR test, metabolic screening, newborn eye prophylaxis, Vitamin K injection)
- Practices to discuss ahead of time with health care provider: such as cutting the cord, circumcision, bonding with baby immediately after birth, breastfeeding/lactation consultation
- Safe sleeping position (on the back), car seat safety, well-child care

Family Adjustment Topics

- Physical and emotional changes
- Sexuality after pregnancy (including safe sex education)
- Protection from secondhand smoke exposure
- Signs of postpartum blues vs. postpartum depression vs. postpartum psychosis
- Potential stresses within family and how to access local supportive resources
- Breastfeeding (nutritional needs of mother, lactation consultation resources)

Recommended Topics Covered in Childbirth Education Classes

Each CBE should be prepared to address the following topics in class, as time allows, either verbally or with handouts, and should know of local resources where clients can get for more information.

- Breastfeeding/bottle
- Shaken baby syndrome
- Importance of well-child care, immunizations, etc.
- Normal newborn appearance, reflexes, characteristics, abilities, and needs
- Infant temperaments, quieting, sleep states, physical appearance, abilities, reflexes, normal stages of development
- When to call the health care provider
- Parenting classes in the community

Whenever possible, classes should be taught in the language of the participant. The client's culture, ethnicity, religion, and values should always be incorporated into the curriculum. All educational materials should be made available to all participants and chosen based upon reading

level, cultural appropriateness, and accuracy. A variety of materials, including videos, charts, and teaching aids may be used.

Transportation

DSHS pays for transportation services to get clients to and from needed non-emergency health care visits. These medical visits must be for services covered by the Medicaid program. Details about transportation services can be found at the following website:

<http://fortress.wa.gov/dshs/maa/Transportation/index.html>

Interpreter Services

The medical service provider (including some MSS/ICM providers) may request Interpreter Services if the client does not speak or understand English or is hearing or visually impaired. Details about these services can be found at the following websites:

<http://fortress.wa.gov/dshs/maa/InterpreterServices/>

http://fortress.wa.gov/dshs/maa/download/Memos/2004Memos/04-57maa_IntptSvc.pdf

Brokered Interpreter Services Fact Sheet

Legal Responsibility: Title VI of The Civil Rights Act Of 1964

Medical providers, as recipients of federal funds, are required to ensure equal access to medical care for their patients, as determined by the Office for Civil Rights. For more information, please refer to the website at <http://www.usdoj.gov/crt/cor/>

Advance Notice Requirements—Regularly Scheduled Request

Requests for interpreter service appointments must be made to the broker at least two full business days in advance, preferably three. Weekends/state holidays are not counted as business days.

Advance Notice Requirements—Urgent Request

Urgent means the Requester has determined the client must be seen on the same day, or next day. The minimum amount of advance notice a broker must have to set up an appointment is usually four hours—applicable to urgent requests only. Sometimes, appointments can be scheduled by the broker with less than four hours notice. Short notice requests should be by telephone to the broker, followed by a faxed paper copy, if required by brokers' policy. If Requester can only give two hours or less notice to the broker, Requester may, at their own expense, seek interpreters.

Advance Scheduling Limit

Medical providers are not normally allowed to request services more than 30 days ahead since HRSA program eligibility is determined monthly.

Unfilled Requests

Some appointment requests can't be filled even if the above guidelines are followed. If brokers are unable to locate interpreters via subcontractors, requesters, at their own expense, may seek interpreters.

Confirmation Process

Broker will confirm with Requester when an appointment has been scheduled. Confirmation normally is completed within two business days of the date of request. Some confirmations may take longer than two business days; especially when the requests are for unique languages or remote locations. Requesters should not send another request just because a confirmation has not been received within two business days. Requester should allow additional, reasonable time for the confirmation to arrive, or call the broker one business day (or 24 hours) before the scheduled appointment time.

Feedback Process

DSHS staff, DSHS contract service providers, and medical providers should notify brokers when interpreters do not show up for appointments, or show up and provide unprofessional services. Feedback is important to prevent inappropriate billings; and allows brokers to develop necessary sanctions to prevent future problems.

Specific Interpreter Requests Based On Medical Necessity

Medical providers may request specific interpreters only when it is medically necessary.

QUESTIONS: 1-800-562-3022

Other Ancillary Resources**Managed Care**

Healthy Options is the DSHS Medicaid managed care program for low-income people in the state of Washington. A website with more information is located at:

<http://fortress.wa.gov/dshs/maa/HealthyOptions/index.html>

Women who are required to enroll in a Healthy Options plan should choose a pediatric provider for her infant that participates in the same plan.

Publications

Health Education and other publications from the Department of Health and Social and Health Services can be found at:

http://fortress.wa.gov/dshs/maa/firststeps/ordering_basic_health_education_.htm

Web Based Resources

There are additional resources on a wide variety of topics at:

http://fortress.wa.gov/dshs/maa/firststeps/web_based_resources.htm

Kid's Health

Information regarding Medicaid coverage for low-income children in Washington State is located at: <http://fortress.wa.gov/dshs/maa/CHIP/Client.html>

Stepping Up Website

Health promotion and prevention strategies for pregnancy, parenting, and infancy were created by the University of Washington, School of Nursing, as a resource for the First Steps Program. Stepping Up is managed by the Washington State Department of Social and Health Services, Health and Recovery Services Administration and the Department of Health, Maternal Child Health and is located at: <http://steppingup.washington.edu>

Community Provider Groups

First Steps provider groups meet in most communities across the state and offer an opportunity for service coordination, resource sharing, and collaboration building. First Steps agency providers, state staff, as well as CSO staff may attend these meetings. Contact First Steps Agency Coordinators in the specific location for details about the meetings in the local community.

Related State Programs

This section is designed to provide MSS/ICM staff with a brief overview and contact information for agencies that may serve First Steps clients.

The First Steps client can receive services from a wide variety of agencies that are directly and indirectly linked to the First Steps Program. Since linkage to systems is a critical part of the First Steps mission, the agency and its employees need to make contact with these other service providers.

It can be challenging to keep linked with the service providers in the community. Good collaborative relationships are dependent upon the following criteria:

- Consistent staffing levels.
- Trust that is built over time.
- Regular positive interactions and exchanges.
- Tangible benefits for the First Steps client.

Chemical Dependency/Substance Abuse Services for Pregnant Women

Chemical dependency/abuse by pregnant women can result in poor pregnancy outcomes in a variety of ways. When an MSS team member identifies women with possible chemical dependency/abuse issues, referral needs to be made to the appropriate DASA program. There are a number of treatment options for pregnant women and new mothers.

Pregnant Women Chemical Dependency/Abuse Resource Guide

The Pregnant Women Chemical Dependency/Abuse Resource Guide is produced and revised by DASA and can be found at: <http://www1.dshs.wa.gov/pdf/hrsa/dasa/PregnantWomenGuide.pdf>. It provides information about available services, contact information, and additional resources. Services include assessment, childcare, hospital-based detoxification, stabilization, treatment, and safe housing. Some residential services can accommodate children.

Women, Infant and Children's Supplemental Nutrition Program (WIC)

Women, Infant and Children's supplemental nutrition program is a preventive health program designed to positively influence lifetime nutrition and health behaviors through supplemental nutrition packages and nutrition education. WIC serves pregnant, breastfeeding, and postpartum women, and children up to age five, who are at or below 185% of poverty, or enrolled in Medicaid, and who have nutrition or medical risks verified by a health professional.

www.doh.wa.gov/cfh/WIC/

Mandatory Reporting Laws

Mandated Reporting Laws [RCW26.44]

All MSS/ICM provider agencies sign a core provider agreement and assurance document with DSHS/Health and Recovery Services Administration. These agreements require that all agencies must follow Washington State laws. This includes the state requirements for reporting child abuse and neglect to local authorities.

The specifics of the mandatory reporting laws may be found at <http://www1.dshs.wa.gov/ca/safety/abuseReport.asp?2>. A short video is also available for viewing that specifically covers “Mandated Reporters.”

Refer to <http://www1.dshs.wa.gov/ca/general/index.asp> to find the local office.

For CPS Publications, please see:

http://www1.dshs.wa.gov/ca/pubs/pubcats.asp?cat=Child_Abuse_and_Neglect

Guidelines for Assuring Staff and Subcontractors are Informed of the Mandated Reporting Requirements

Each provider agency is responsible for assuring staff and subcontractors are informed of the responsibilities of mandated reports.

The following strategies are suggested to assist individual professionals and agency coordinators follow the law:

- In-service training.
- Supervisory follow-up on at-risk or potential at-risk cases.
- Development of strong relationships with local Child Protective Services office staff.

Agencies can implement these strategies in the following ways:

In-service Training

- Schedule training for all staff two times per year as part of the in-service schedule. Invite local CPS trainers to staff meetings to review the mandated reporting laws, CPS policies, and updates on new information.
- Assist staff in how to report abuse and neglect by using role play, modeling from senior workers, and supervisory support.
- Develop intra-agency methods for supporting staff with reporting.

Supervisory Follow-Up

- Track and discuss the rate of referral in the agency with staff during supervisory conferences.
- Provide a forum in staff meetings for staff to discuss issues and concerns regarding mandated reporting.

Development of Strong Relationships with CPS

- Set up a method of consultation with CPS that allows staff to discuss a possible referral.
- Set up a procedure for referral with CPS that allows for more client-sensitive referral processes and leads to better collaboration.
- Ask for support from CPS supervisors when problems occur rather than avoiding the agency and staff. Try to work out issues in an open forum.



CPS has Policies and Standards that it must adhere to when receiving referrals. CPS makes the final decision about each case based on a number of factors including risk to children and parent protective factors. A sample *First Steps Referral to Child Protective Services* to send to Child Protective Services is included in this manual in [Appendix IV](#) should a provider agency chooses to use it. Some agencies have already developed similar forms to use. It is up to the First Steps management in each agency to decide whether to use the form.

Developmental Disabilities Services

Occasionally, MSS/ICM team members will encounter a pregnant woman who has a developmental disability or a family may have a child who is eligible for services through this program. It is important as a First Steps provider to know local resources, referral processes, and eligibility criteria. It is just as important for staff in Developmental Disabilities to be aware of the services First Steps offers so that every woman and her family have the most support possible.

DDD

The Division of Developmental Disabilities (DDD) is part of the Department of Social and Health Services. DDD assists individuals and their families to obtain services and support based on individual preferences, capabilities and needs that promote everyday activities, routines and relationships common to most citizens. DDD uses state and federal funds to provide or purchase services and support for eligible persons and their families.

For more information, see: <http://www1.dshs.wa.gov/ddd/services.shtml>

Family Health Hotline

If a woman has a question or a concern about her baby's development, call the Family Health Hotline operated by WithinReach (formally Healthy Mothers, Healthy Babies) at 800-322-2588 for the name of the lead Family Resources Coordinator in their county.

Infant Toddler Early Intervention Program

Additional information is available at the Washington State Infant Toddler Early Intervention Program website <http://www1.dshs.wa.gov/iteip/>.

Mental Health Services

The Washington State Mental Health system has a limited set of crisis services for the general state population and more extensive services for people on Medicaid that are managed locally by Regional Support Networks (RSNs). This section will assist in finding connections to this system that may be helpful.

Mental Health Services Provided to the General Population

Crisis and Commitment Services: Regional Support Networks are required to purchase or provide 24 hour a day crisis response services for those in a mental health crisis. Every county has a toll free crisis line. Contact information for the crisis lines can be found in the emergency section at the front of most phone books and on the Mental Health Division website:

<http://www1.dshs.wa.gov/Mentalhealth/>. Local mental health services throughout Washington State are also listed on the division's website.

Mental Health Services for People Receiving Medicaid Benefits (Enrollees)

Community Mental Health Agencies have contracts with Regional Support Networks to provide services to those who are covered by Medicaid. All Medicaid enrollees are entitled to:

1. An intake evaluation to determine medical necessity.
2. Crisis and stabilization services.
3. Inpatient mental health treatment if determined to be medically necessary.

If medical necessity is met at the time of the intake evaluation, then community support services may be provided. These services include but are not limited to:

- Brief therapy.
- Individual services such as case management.
- Medication management.
- Group therapy.

Family Planning Services

Family planning and other primary health care service is the key to improving the health status of women. Most women of childbearing age receive primary care at the place where they get annual reproductive health checkups and birth control. Preventive services such as pap smears, breast exams, and follow-up of other medical conditions are provided. Women may choose private providers, managed care plans, community health clinics, Planned Parenthood, Community Services Offices (CSOs), or other family planning agencies.

It is important to ensure that women have a source of ongoing women's health care, they have an easy transition into this care, and they have adequate access to a variety of birth control options. This type of care is an investment in subsequent birth outcomes, which are improved if the interval is at least 24 months between births.

Guidelines for Enhancing the First Steps Family Planning Continuum of Care

1. Have local family planning health educators provide counseling/education at MSS/ICM agencies, and/or teach that topic within the childbirth education class (potential partners include local family planning agency, CSO Based Family Planning Nurse or other provider).
2. Provide cross-training sessions between local family planning providers and MSS/ICM agencies (possible contacts are local family planning agency, CSO Based Family Planning Nurse, or other providers).
3. Ensure family planning agency and primary care representation on local First Steps Community Advisory Committees.
4. Set up a meeting of Maternity unit staff, family planning and First Steps agency staff to discuss the feasibility of providing a supply of foam, condoms, and emergency contraception with family planning information and referral sources to clients before they leave the hospital or at a near term MSS visit. These kits could be colorful and attractive. Go to area community groups with ideas and ask for funding. Potential partners in creating the kits are pharmaceutical representatives, TAKE CHARGE Providers, CSO Based Family Planning Nurse, and local family planning agencies.
5. Negotiate user-friendly transition procedures if the agency provides the prenatal medical care but not the ongoing women's health care. Examples include: Copy post partum physical exam and agency's physical exam form: keep a copy for the agency's own records while forwarding the original to the provider; provide an early post partum visit and refer client to the follow up agency for the traditional post partum exam; or negotiate use of family planning staff in the agency to provide the post partum exam and orient the client to other facility for subsequent care.
6. Set up a meeting with CSO-based Family Planning Program to ensure low-income women in their third trimester of pregnancy get Family Planning Information and referral resources.
7. Promote knowledge of emergency contraceptive pills (ECP). Learn more about ECP from the local family planning agency. Find out which providers in the area provide ECP. Provide clients with contacts and information. Keep this information updated and visible.
8. Collaborate with the First Steps/Family Planning program manager in each DSHS Region.

To find out more about family planning services visit the following website:

<http://fortress.wa.gov/dshs/maa/familyplan/>

Discipline Specific Qualifications and Job Descriptions

This section covers First Steps discipline-specific qualifications and job descriptions for:

- [Community Health Nurses](#)
- [Behavioral Health Specialists](#)
- [Registered Dietitians](#)
- [Community Health Workers](#)
- [Infant Case Managers](#)

Community Health Nursing Qualifications and Job Description

Qualifications

Current licensure in the State of Washington as a Registered Nurse is required.

Education and experience requirements:

1. Bachelor Degree in Nursing. Recently **licensed** graduates or those returning to the work force with a Bachelor Degree in Nursing are **recommended to have a six month** training/ clinical supervision and mentoring plan provided by employing agency to document progress and experiences that enhance knowledge and skills in community maternal child health nursing.
–OR–
2. Two year Associate degree or three year diploma in nursing with a minimum of two years experience in community maternal child health nursing plus documented continuing education in community based maternal child health nursing topics such as lactation, parent infant interaction, domestic violence, motivational interviewing, chemical dependency, family planning.
–OR–
3. Two year Associate degree or three year diploma in nursing with at least two years nursing experience but limited nursing experience in the community health setting. An approved **one year** training/ clinical supervision and mentoring plan is required to document progress and experiences that enhance knowledge and skills in maternal child community health nursing. The plan needs to be submitted for approval to the First Steps State nurse consultant within 60 days of hire.

Registered Nurses are required to obtain one year of clinical experience in maternal child nursing before being employed as a MSS Community Health Nurse.

Registered Nurses returning to the work force after several years since licensure and with no or very limited experience in providing nursing services, are required to obtain one year of clinical experience in maternal child nursing before being employed as a MSS Community Health Nurse

Job description

Maternity Support Services (MSS) nursing is a practice discipline where the client is believed to be a bio-psychosocial, cultural, and spiritual being whose health and illness continuum are interactive with family and environmental conditions. MSS community health nursing should reflect a self-care orientation where the nurse supports the woman in accomplishing self-care and decision making for the health and wellbeing of her self and infant during pregnancy and the post pregnancy period. Nursing services should be offered within an individualized, family centered, community based and culturally competent framework.

The community health nurse's role includes:

1. Screening for high risk factors and providing nursing assessment of the pregnant/parenting woman and infant.

2. Initiating, consulting and/or participating in development, implementation, and evaluation of client service plan depending on the primary needs of the woman and/or infant, and referring client to other team members as risk factors and plan indicate.
3. Providing preventive health education. Topics should include but are not limited to:
 - a. Self care during pregnancy and postpartum period including recognition of warning signs of complications or early labor
 - b. Care of acute or chronic illness
 - c. Pregnancy planning and family planning methods
 - d. Parenting and health care for the infant including accident prevention and SIDS risk reduction
 - e. Recognition of signs of stress and interventions to moderate stress
 - f. Symptoms of depression and appropriate resources to address them
4. Providing support, advocacy, referral, and linkage for health care needs of the mother and infant with primary medical care provider and community. (Case Management services).
5. Providing nursing care consultation to the MSS interdisciplinary team regarding health care needs of the woman in the pregnancy cycle, her infant, and family.
6. Participating in quality assurance activities and system development within the MSS/ICM agency.

Essential Functions

Screening /Assessment:

Assure that a client centered, culturally sensitive, pregnancy risk screening is done on all MSS clients. As indicated, a maternal child health nursing assessment should be completed on women/infants identified as having medical risks. A nursing assessment should focus on the risk factors identified in Core Services and could include questions exploring the following:

- Health Perception/Health Management: i.e. breast feeding intentions, compliance with medical care, immunizations, environmental risks, health history
- Nutritional/Metabolic: i.e. anemia , weight gain, gestational diabetes
- Elimination: i.e. Urinary tract infection, frequent urination, constipation
- Activity/exercise: i.e. exercise routine, activity intolerance, resources
- Sleep/Rest: i.e. Adequate sleep and rest, sleep pattern disturbances
- Cognitive/Perceptual: i.e. problem solving abilities, understanding changes during pregnancy/postpartum.
- Self-perception: i.e. anxiety, fatigue, fear, loneliness
- Role/Relationships: i.e. isolation, grieving, history of altered parenting, support system

- Sexuality/Reproductive: i.e. safe sexual practices, dysfunction during pregnancy, family planning decisions
- Coping/Stress tolerance: i.e. current/past sources of stress, coping skills
- Values/Beliefs: Beliefs regarding health care, future goals, cultural practices related to parenting and health care.

Health education/interventions:

Provide health education/interventions as a part of nursing visits in either the home or clinic setting.

Documentation:

Maintain clinical records that contain completed risk screening, health education messages and linkages, nursing assessments, documentation of any case-conferencing and interdisciplinary service care plans, nursing interventions, follow-up care and outcomes of interventions. Application of legal mandates for reporting abuse/neglect must be documented.

Team Participation:

Cooperate, coordinate, communicate and provide standardized care through the interdisciplinary team interventions to enhance Maternity Support Services capacity for client-centered, continuous and reliable care. Assign and monitor activity of CHW related to nursing issues and document.

Policy and System Development:

Provide administrators and policy makers with data regarding health care needs of the MSS/ICM client population, develop positive relationships with other provider organizations serving the population and provide leadership in promoting collaboration between community and state wide agencies.

Knowledge and Skills

General for pregnancy, post-pregnancy, and infant care up to two months of age.

1. Effective oral and written communication skills.
2. Assessment and intervention skills to perform community health nursing care and health education in clinic, office, and home or community setting.
3. Counseling skills to recognize and support health behavior change.
4. Awareness and decision-making abilities for assessing risk to self from client or unfolding situation.
5. Knowledge of pregnancy, family planning, post-pregnancy issues, infant care, parental adjustments.
6. Ability to form and sustain effective relationships with clients, team members and community health and social service providers.

7. Understanding of maternal infant health nursing, community based health systems, and community's socio-economic system.
8. Ability to be flexible, manage time, resources, and client caseload.
9. Demonstrate respect and appreciation for diversity (culturally relevant, anti-bias, and multicultural).
10. Demonstrate a willingness/ability to work with the interdisciplinary MSS team to provide optimum care.

Qualifications: MSS Community Health Nurse must be a Registered Nurse in the State of Washington and meet the qualifications as outlined in the MSS/ICM Billing Instructions.

The RN license needs to be renewed annually. Working without a current license may result in a fine for the individual and an overpayment for services billed.

Mentoring and Training Plan

A mentoring and training Plan is required for Registered nurses who have:

1. Less than one year's experience in Maternal Child Health Nursing in the community setting which includes home visiting
–AND/OR–
2. Limited continuing education on maternal child health community health nursing topics; i.e. domestic violence, tobacco cessation intervention, family planning methods, parent child interaction (N-CAST), drug and alcohol addiction, parenting, maternal depression, preventive health care for the newborn and infant.

The mentoring/training plan goes beyond First Steps Maternity Support Services and Infant Case Management orientation to be provided to the nurse within 60 days of hire. It should be based on the individual needs of the nurse determined by past experiences, continuing education completed and/or other degrees obtained related to health care provision.

Sample Plan:

- Review past continuing education classes for training listed in #2 above, to determine familiarity with topics related to Maternal Child Nursing during the pregnancy cycle up to the infant's first year of life. Optimum time frame for classes completed would be within the last five years.
- Discuss self-identified training needs with the nurse and what the supervisor or mentor identifies as needs to support adaptation to the community health nurse role on the First Steps Team.
- Arrange for the nurse to accompany/observe more experienced nurses and other team members in clinic and home visits. Provide debriefing with time to ask questions. Plan should include how often and for what length of time accompanied visits should occur based on agency and nurse needs.

- If the nurse has minimal obstetrical experience and agency has obstetrical/pediatric medical care providers on site, it would be beneficial for the nurse to review protocols with the medical care providers and then observe clinical assessment, treatment protocols as well as the referral process, if indicated. After observing, debriefing time should be scheduled with provider
- Provide opportunities to connect with other MSS/ICM nurses in the agency and community linkages to review clinical challenges, and share learning resources.
- Provide opportunities to review clinical work with nurse at least weekly to begin and at least monthly after experience is established in client service delivery and community networking for one year.

The mentoring, supervision and training plan will vary based on the needs of the nurse, the client population she serves and the characteristics of the agency. This sample plan provides suggestions of what should be included and submitted to the state to be reviewed and then placed in the agency record.

Resources

1999 Region X Nursing Network Prenatal, Postpartum, and Newborn Manuals.

Behavioral Health Specialist Qualifications and Job Description

Qualifications

Current license in the State of Washington as a Social Worker, Mental Health Counselor, Marriage and Family Therapist, or Psychologist is preferred.

–OR–

Registered as a counselor in the state of Washington with a Master's degree in Psychology, Social Work, Marriage and Family Therapy, Counseling or Educational Psychology from an accredited school with an internship or practicum experience in direct counseling services and one year (40-hour week, not internships or practicum) supervised experience with direct counseling services to clients. A Master's prepared person who does not have one year of supervised work experience requires clinical supervision as described below in until they have completed the one year experience requirement.

–OR–

A registered counselor in the state of Washington with a Bachelor's Degree in Psychology, Social Work, or Educational Psychology from an accredited school plus two years of supervised experience in direct counseling services to clients. Ongoing clinical supervision is required for Bachelors prepared staff while in this position.

Job Description

Position Summary

The Behavioral Health Specialist's role on the First Steps Team is to provide brief, culturally relevant counseling interventions, education and case management for First Steps clients based on identified needs and in keeping with the identified core services. The Behavioral Health Specialist serves as a consultant to the MSS team in developing the comprehensive Plan for Care. The Behavioral Health Specialist role is vital to the First Steps goal of increasing client self-sufficiency and control over their lives.

The MSS Behavioral Health Specialist position requires flexibility, strong assessment and intervention skills, and the ability to blend social work practice with the overall functioning of the MSS team, in a limited time frame. The Behavioral Health Specialist will utilize the client's identified priorities, information from the screening tool, professional observation and assessment to participate with the other members of the MSS team in developing a comprehensive Plan for Care for the maternity cycle.

Brief Overview

The Behavioral Health Specialist provides:

- Expertise on psychosocial issues, mental health including diagnostics, strategies for facilitating client change, community resources and improving self-care techniques to promote emotional well being

- An intervention plan developed with the client and other team members based on the client's identified needs, screening tool, additional evaluation and assessment of identified risk areas
- Brief treatment and/or transition services to ongoing treatment based on the plan for care
- Consultation to the MSS/First Steps Team regarding the psychosocial needs of pregnant women and their families and provision of social services
- Case Management functions including referral, linkage and advocacy during the maternity cycle
- Policy and system development

Essential Functions

Screening/Assessment Function:

Complete or review the MSS Screening Tool with client and provide additional assessment for identified risk factors in a culturally sensitive manner. The assessment may include, but is not limited to:

- Current family functioning
- Individual History: cultural background, health status, substance use/abuse, violence, legal involvement
- Review of support systems: formal/informal
- Basic physical needs (such as food, housing, clothing)
- Education/vocation needs
- Psychosocial stressors
- Screening for mental health concerns
- Family history or genogram

Intervention:

Provide brief, culturally relevant counseling¹ and crisis intervention to clients on areas identified in screening/assessment. Counseling issues may include: crisis intervention, pregnancy and birth options, family planning methods, grief issues, stress, parenting, coping skills, problem solving, abuse/neglect, drug alcohol issues, family violence and mood disorders.

Educate clients toward informed choices regarding personal, child and family health/mental health treatment.

Assist in empowering clients to advocate for themselves.

¹ Brief counseling is defined as limited to the time constraints of MSS eligibility and client need. Counseling will assist clients in developing some control and self-sufficiency in the areas defined.

Case Management:

Provide resource and referral interventions to assist clients during the maternity cycle in accessing community resources for basic needs, health care and social services.

Documentation:

Maintain records that contain comprehensive behavioral health assessment information, clear, concise plans for care; treatment/follow up care and progress toward outcomes. Application of legal mandates for reporting abuse/neglect must be documented. For additional guidelines for record keeping and retention see [WAC 246-810-035].

Team Participation:

Participate in all team meetings to:

- Provide behavioral health consultation and service planning
- Assist with problem solving, team communication and interdisciplinary decision-making
- Coordinate services among community and team providers
- Assign and monitor activity of CHW related to psychosocial issues and document

Policy and System Development:

Provide administrators and policy makers with data regarding behavioral health needs of the MSS client population; develop positive relationships with other provider organizations serving the population and provide leadership in assuring that all providers work collaboratively in addressing the needs of the MSS client population.

Knowledge and Skills

- Effective oral and written communication skills
- Ability to form and sustain effective relationships with clients, team members and community providers
- Understanding of community systems
- Demonstrates respect and appreciation for diversity (culturally relevant, anti-bias, and multicultural)
- Understanding of federal, state and county regulations as they pertain to social services and specific professional licensure
- Ability to manage time, resources and client caseload
- Knowledge of human growth and development, throughout the life span
- Knowledge of brief counseling techniques and crisis intervention
- Knowledge of behavioral change theories and practice
- Knowledge of pregnancy and post pregnancy issues

- Ability to provide effective consultation
- Knowledge of poverty, family disorganization and health issues

Mentoring and Training Plan

Supervision

Clinical supervision will be provided by a licensed Social Worker, Mental Health Counselor, Marriage and Family Therapist, Psychologist or by a person possessing a Masters degree in Counseling, Social Work, Psychology, or Marriage and Family Therapy who has at least two years of clinically supervised direct counseling experience.

A supervision plan, approved by the First Steps state Behavioral Health Specialist Consultant, is required. The supervision plan will include dates of clinical supervision, the name and credentials of the clinical supervisor and specific topics or issues to be addressed in a given session and other skill development activities that may apply.



Changes to the qualifications for supervisors of individuals working towards licensure have been proposed—it is the individual's responsibility to keep informed of the requirements for licensure.

Guideline for Supervision Learning Contract

General Information:

The following information should assist in the development of a learning contract between a clinical supervisor (referred to as Supervisor) and the individual receiving clinical supervision services (referred to as Clinician). Both clinician and supervisor should have a clear understanding of the following:

1. The Supervisor will provide the Clinician with a resume or Curriculum Vitae which lists education, degrees, certification/licensing status, experience, post-masters training, areas of expertise, supervisors disclosure statement and malpractice insurance coverage.
2. The Clinician being supervised will provide the supervisor with a resume listing education, degrees, post-bachelor /post masters experience and a summary from a practicum supervisor (if applicable) or most recent supervisor, certification status, share disclosure statement and malpractice insurance coverage.
3. Establish a written plan for supervision which includes but is not limited to the following:
 - Amount of time and schedule for supervision
 - What areas the supervision will include (case review on all cases, focus on specific cases; focus on specific skills)

- Confidentiality agreement to share case information based on individual agency or private practice professional need (i.e. supervision should be listed in the Clinician's disclosure statement). Are there client consents and supervisor's signatures on the agency confidentiality agreement? How is information protected? How will the management of mandated reporting of child abuse or abuse of vulnerable adults be handled?
- Establish a learning contract that includes other forms of supervision that may be covered by other supervisors
- Who will record the supervision time, in writing? Where will records be kept?
- Establish relationships between work site and supervision (for example, can supervision information be provided to work site supervisor if this is a different person)

Educational Assessment:

This assessment can be filled out at the beginning and at various stages of the supervision to track progress and the relevancy of the supervision provided. Initially the Clinician can fill this out as a basis for discussion in designing the learning contract. During the process of supervision both the Supervisor and Clinician can fill out the assessment as a reference for further planning supervision sessions.

1. The clinician should identify his/her strengths and areas for future growth.
2. The clinician should identify the methods by which he/she learns best (observation, reading, discussion, task assignments, journal keeping, role-plays, and scenarios).
3. Summarize a review of written documentation on client records. What are the strengths and weaknesses?
4. Summarize the clinician's skill and understanding of cultural competency. List strengths and areas for improvement.
5. Summarize clinical skills in face to face encounters with clients. List strengths and areas for improvement.
6. List strengths and areas for improvement on: Community linkage; Community mobilization; Advocacy.
7. Other assessment information as needed.

Supervisor Learning Assessment:

Review the following with the clinician:

- A sample of a written intake assessment
- A sample of a set of chart or progress notes with initial assessment material
- The clinician disclosure statement

- A copy of any employee evaluations from previous work
- Clinician's educational assessment (above)

Learning Contract:

After completing this set of information the supervisor and clinician will develop a learning contract with the following elements:

- Plan for Supervision (basically all of #3 in General Information Section above)
- Areas of Focus for Supervision
- How issues of confidentiality will be handled
- Methods of supervision that will be used
- When supervision contract will be reviewed and revised
- Attach any supplemental information (such as the Educational Assessment, Resumes, Disclosure statements or any other material) that may be important to this effort

Send information to the Behavioral Health Consultant (see [*First Steps State Contacts*](#)).

Additional Information

Registration or licensure must be renewed annually on the individual's birthday. Working without a current registration or license may result in a fine for the individual and an overpayment for services billed to Medicaid.

All Behavioral Health Specialists, by law, are to have a disclosure statement. For information on the required content of the disclosure statement see *[RCW 18.19.060]* and *[WAC 246- 810-0303]*.

All Behavioral Health Specialists are strongly encouraged to pursue licensure as it is anticipated licensure may be required in the future.

Registered Dietitian Qualifications and Job Description

Qualifications

- Currently registered with the Commission on Dietetic Registration (RD)
- One to two years experience in public health and/or maternal and child health is preferred



Please note: Some registered dietitians (RD's) call themselves nutritionists, but not all nutritionists are RD's.

Job Description

The Registered Dietitian on the First Steps team must be knowledgeable about maternal and infant nutrition needs during the maternity cycle and have the ability to blend nutrition professional skills and integrate services with the team.

A brief overview of the Dietitian's role is to provide:

- MSS screening (as needed) and nutrition assessments focused on the maternity cycle
- Education and counseling that is client centered
- A nutrition care plan with client input that is incorporated into the interdisciplinary plan of care
- Guidance to CHWs providing nutrition services
- Consultation to the First Steps Team regarding the nutritional needs of the client and their family
- Policy and system development, as needed

Essential Functions

MSS Screening

Depending on the agency setup, some RD(s) routinely screen MSS clients using the required forms. Other agencies may be limited on RD time and may use other professionals to provide this piece of the program. Regardless of setup, all RDs need to be aware of the screening process and should be able to provide screening as needed. It is important to note that if a RD finds themselves as the only MSS provider that they are required to follow and complete any screening required by the program. Please see documentation requirements for more detail on screening requirements.

Assessment

Assure that a thorough, culturally sensitive nutritional assessment is completed. The nutrition assessment includes but is not limited to:

- **Dietary Intake:** Assess nutrient intake in comparison with recommended nutrient intake for pregnancy, lactation, post-partum, and infancy periods. Evaluate issues influencing intake such as; nausea, vomiting, heartburn, constipation, available resources, finances, environment, transportation, and family beliefs etc. Assess vitamin/mineral supplementation, medications, eating disorders, and any form of pica.
- **Anthropometrics:** Assess pre-pregnancy BMI, height, weight gain through pregnancy plotted on a grid appropriate for pre-pregnancy body mass index (BMI), and client weight goals.
- **Biochemical/Clinical Assessment:** Review health history and status, pregnancy risk factors, lab values (hematocrit or hemoglobin), drug nutrient interactions, physical activity level, smoking, and substance abuse.
- **Psychosocial/Environmental:** Evaluate adequacy of food supply, household resources and food management skills. Assess client's stress level, support system, parenting and impact of family's cultural beliefs on eating behaviors. Assess client's goals for work, education, family planning and parenting that might impact infant feeding and finances. Assess impact of family's cultural beliefs on eating, nutrition and parenting.

Nutrition Education and Counseling

- Provide face to face, client centered counseling
- Provide nutrition information based on best practices and current nutrition standards
- Provide handouts and referrals as needed
- Refer to another nutrition specialist and/or other specialized care, if advised (e.g. eating disorders treatment program, intensive diabetic self-care management approach, substance abuse program)
- Comply with legal mandates for reporting abuse/neglect

CHW Guidance

- Provide guidance, as needed, to CHW(s) that may be providing some basic nutrition information to clients
- A CHW should be supervised by one of the members on the First Steps team and this member could be the RD depending on the agency. Please see more information on CHW supervision requirements in the CHW section of the manual.

Documentation/Plan for Care

- Maintain clinical records that document comprehensive nutrition assessments, clear and concise care plans; nutritional counseling/follow-up care and progress toward outcomes
- Develop a care plan based on the client's individual needs/goals and MSS team input

- Information must be in the First Steps central chart and on the MSS interdisciplinary care plan
- See documentation requirements for more details

Team Participation

- Participate in case conferencing
- Provide nutrition consultation and care planning
- Assist with problem solving and interdisciplinary decision-making
- Coordinate nutrition services among community resources and team providers
- Communicate and collaborate with ICM case managers as needed

Policy and System Development

- Provide administrators and policy makers with information regarding nutritional needs of the MSS/ICM client population
- Develop positive collaborative relationships with other provider organizations serving this population
- Provide leadership in assuring that all providers work collaboratively in addressing the nutrition needs of the MSS/ICM client population
- Use internal quality control checks to ensure good client care

Knowledge and Skills**General Knowledge and Skills:**

- Effective oral and written communication skills
- Ability to perform services in clinic, office, or home visit setting
- Knowledge of pregnancy, post partum issues, infant care, parental adjustments
- Ability to form and sustain effective relationships with clients, team members and community health and social service providers
- Understanding of medical nutrition therapy, community based health systems, community resources and community's socio-economic system
- Ability to manage time, resources, and client caseload
- Demonstrate respect and appreciation for diversity (culturally relevant, culturally sensitive)

Scope of Practice and Best Practice (Based on American Dietetic Association):

- Collaborate with clients to assess needs, background, and resources available to establish mutual goals
- Collaborate with other professionals
- Implement quality practice by following policies, procedures, legislation, licensure, practice guideline, and the standards of professional practice
- Continuously evaluate processes and outcomes
- Advocate for the provision of food and nutrition services as part of procedure and policy
- Base practice on sound scientific principles, research and theory
- Communicate evidence-based scientific principles, research and theory
- Integrate knowledge of food and human nutrition with knowledge of social sciences and motivational interviewing
- Seeks out information to provide effective services
- Educate and help clients and others to identify and secure appropriate resources
- Document outcome of services provided
- Continuously evaluate and refine services based on measured outcomes
- Engage in lifelong self-development to improve knowledge and enhance professional competence
- Conduct self-assessment at regular intervals to identify professional strengths and weaknesses
- Adhere to the code of ethics for the profession of dietetics and be accountable and responsible for actions and behavior

Suggested Training

- First Steps online training for Dietitians
- WIC Nutritionist training for WIC/MSS staff
- Breastfeeding training at Evergreen Hospital or via MSS/WIC
- National Maternal Nutrition Intensive Course—University of Minnesota.
- Tobacco and family planning training
- Cultural diversity
- Ethics
- Motivational Interviewing

Resources

Contact the First Steps nutrition consultant if there are any questions (see [First Steps State Contacts](#)).

Following are some resources to help build skills and increase the knowledge base for dietitians.

Websites:

First Steps: www.fortress.wa.gov/dshs/maa/firststeps

Women Infant and Children's Supplemental Nutrition (WIC):
<http://www.doh.wa.gov/cfh/WIC/default.htm> and www.walwica.org and
www.nal.usda.gov/wicworks

American Dietetics Association: www.eatright.org

Washington State Dietetics Association: www.nutritionwsda.org

Bright Futures: www.brightfutures.org/bf2/about.html

Children with Special Health Care Needs: www.doh.wa.gov/cfh/mch/cshcnhome2.htm

Institute of Medicine: www.iom.edu

La Leche League: www.lalecheleague.org

WithinReach (formally Healthy Mothers Healthy Babies) www.withinreachwa.org

Washington State Dairy Council: www.eatsmart.org

American Academy of Pediatrics: www.aap.org

Manuals/Books:

- Maternal and Infant nutrition training guide from www.nutritiondimension.com
- American Dietetics Association Manuals for adults and pediatrics
- Nutrition During Pregnancy and Lactations from the Institute on Medicine
- Communication and Education Skills; Betsy B. Holly and Richard J. Calabrese

Community Health Worker Qualifications and Job Description

Community Health Worker (CHW) is an optional MSS Staff Position. All CHW activities must be carried out under the direction and clinical supervision of at least one of the professional members of the MSS team. To request technical assistance about the development of a CHW supervision plan, call the DOH Health Education Consultant (see [First Steps State Contacts](#)).

Qualifications

Required qualifications for this position are:

- A high school diploma or the equivalent,
- One year of health and/or social services experience, and
- A documented orientation, training and supervision plan.

Recommended qualifications for this position include:

- Being part of the local community: meaning the CHW reflects the linguistic, ethnic, cultural and socio-economic characteristics of the community
- Having experience with the target population in the community
- Having status as a positive role model in the community
- Demonstrating the ability to be trusted to work independently and as part of the MSS team
- Having a clear understanding of the federal, state, and community resources available
- Possessing the ability to conduct reliable education and outreach in the community
- Clearly understanding and agreeing to the parameters of this role
- Knowing when, why and how to refer to the MSS professional team members appropriately
- Agreeing to meet the needs of the clients, by providing unbiased and accurate education and/or referral(s), even if the clients' needs might be in conflict with the personal viewpoint/belief system of the CHW

Job Description

The CHW's primary role is to provide supplemental and basic health messages and safety education to clients. CHWs may provide services in the home or in the office. CHWs are to be included in the development of the plan of care and case conferences.

With appropriate and documented supervision, experience, and training a CHW's scope of practice may include:

- Enrolling and orienting new First Steps clients

- Explaining the scope of services available through MSS and ICM programs to new clients
- Assisting clients in filling out the Client Questionnaire and reviewing the initial Screening Tool with new clients
- Working with clients directly to identify basic risk factors and needs
- Assisting clients plan and carry out the MSS plan of care
- Assisting clients access appropriate health care and local services in the community
- Providing health and safety related messages as related to the Minimum Interventions, such as, but not limited to:
 - Nutrition education
 - Avoidance of harmful substances during pregnancy education
 - Family planning services
 - Lactation education
 - Tobacco Cessation and reducing second hand smoke exposure
 - Safe car seat use



MSS reimbursement is NOT available for these services that might be carried out by an agency staff member whose job duties also include providing CHW services: a) Providing ONLY interpreter services b) Agency clerical work c) Providing transportation.

Mentoring and Training, Orientation and Observation Requirements

Prior to billing for any CHW services, and before any one-on-one activities occur between a CHW and client, the following CHW-specific orientation, training, and observations must be successfully completed and documented in the CHW's personnel file and a copy sent to the state CHW consultant.

Instructions for Orientation of the First Steps Community Health Worker

The CHW is to be oriented to what his/her individual scope of practice is in providing client services by using the [Orientation to Essential Functions Checklist](#).

Before a CHW observes and/or conducts a supervised visit, they must be oriented by their designated supervisor using this checklist as a training guide, and by signing and dating the checklist the observer and CHW trainee acknowledge that they have reviewed the results together. Upon successful completion of the checklist, the CHW will demonstrate:

1. A clear understanding of what his/her role and responsibilities will be in carrying out assigned activities with clients.
2. A clear understanding of and agreement to carry out his/her part in a client's total plan of care.
3. The skills and capacity to interact with clients on a one-on-one basis.

In addition, each CHW shall have at least twelve (12) hours of supervised visits prior to conducting unsupervised visits:

- The CHW trainee is required to observe each professional member of the MSS team interact with a client. (The professional team consists of the community health nurse, the behavioral health specialist, and the registered dietitian). The trainee must observe members of the MSS professional team interacting with clients in at least three home visits (4.5 hours) and one office visit (1.5 hours), totaling six hours.
- The CHW must be observed by a professional member of the MSS team for at least six hours interacting successfully with clients in at least three home visits (4.5 hours) and one office visit (1.5 hours) for a total of six hours. During this observation period, the experienced professional team member shall check off the CHW's demonstrated competencies on the orientation checklist and sign it, followed by a review between the Supervisor and the CHW.

Community Health Worker Orientation to Essential Functions Checklist

This document can be used as a Microsoft Word-based form. The file needs to be protected to access the form (Tools> Protect Document: no password). To answer the questions, click in the appropriate shaded checkbox(es) or click in the shaded blank fields and type in textual information.

The pages can also be printed and used as a paper-based form.

A. The CHW conducts pre-visit planning activities

- ☐ Plans travel route and transportation needs
- ☐ Develops objectives for the office and/or home visit
- ☐ Gathers/prepares handouts and materials in advance
- ☐ Organizes materials for the visit
- ☐ Obtains supply of First Steps information forms and documents
- ☐ Confirms appointment time and place
- ☐ Leaves appointment schedule with First Steps agency office and/or supervisor when conducting a home visit

Other:

Date & Signatures

CHW: _____

Supervisor: _____

B. The CHW demonstrates how to develop an appointment schedule

- ☐ Meets with First Steps multidisciplinary care team to know what appointments to schedule
- ☐ Plans the length of the visit
- ☐ Plans travel time between visits
- ☐ Involves client and First Steps team in scheduling the date, time, and length of the visit.
- ☐ Plans for other staff duties or conflicts when preparing CHW visit schedule
- ☐ Maintains an appointment book or scheduling calendar with references and important phone numbers

Other

Date & Signatures

CHW: _____

Supervisor: _____

C. The CHW demonstrates the appropriate initiation of

Date & Signatures

a visit

- ☐ Arrives on time to the scheduled visit
- ☐ Greets client/family members appropriately
- ☐ Identifies self to the client and/or family
- ☐ States purpose and objectives of the visit
- ☐ Helps client focus during visit

Other

CHW: _____

Supervisor: _____

D. The CHW uses appropriate communication skills

- ☐ Understands and demonstrates ability to effectively use a client centered approach at all times
- ☐ Exhibits positive, polite, respectful attitude
- ☐ Clarifies client role as a partner
- ☐ Uses praise and encouragement effectively
- ☐ Practices good listening skills
- ☐ Uses easy to understand language
- ☐ Uses reflection, clarification, paraphrases client's feelings and concerns
- ☐ Gives appropriate nonverbal cues to the client
- ☐ Does not interrupt the client
- ☐ Avoids gossip, or discussion of any other clients' situations or information
- ☐ Is sensitive to client's cultural and religious customs
- ☐ Encourages client to verbalize questions or concerns
- ☐ Encourages and acknowledges healthy behaviors in the client
- ☐ Discusses sensitive issues in a tactful manner
- ☐ Is flexible in dealing with unexpected situations and/or reactions

Other

Date & Signatures

CHW: _____

Supervisor: _____

E. The CHW identifies and uses appropriate resource and support materials for the client

- ☐ Resource materials support visit objectives and have been approved by supervisor
- ☐ Materials are explained and reviewed with the client
- ☐ Client is given instructions about what to do if she has additional questions
- ☐ If client wants extra copies, CHW arranges for that if possible

Other

Date & Signatures

CHW: _____

Supervisor: _____

F. The CHW refers clients to appropriate resources and/or services

- ☐ Looks for referral opportunities with the client
- ☐ Explains to client that CHWs are NOT medical or mental health professionals
- ☐ Avoids giving any medical or mental health treatment or advice to client at all times
- ☐ Gives accurate information to the client about referrals and community resources
- ☐ Assists client in completing access to the referral, if necessary
- ☐ Informs client how CHW will follow up with client on the referral(s)
- ☐ Knows “red flags” when to refer client for immediate medical intervention

Other

Date & Signatures

CHW: _____

Supervisor: _____

G. The CHW uses appropriate personal safety and security measures in conducting home visits

- ☐ Provides supervisor/office with home visit schedule
- ☐ Secures personal valuables in a safe place, or avoids bringing

Date & Signatures

valuables on the visit

- ☐ Attire is appropriate for home visiting
- ☐ Has a plan for where to go and what to do in an emergency
- ☐ If driving, checks car for gas and proper maintenance before leaving office
- ☐ Locks and secures vehicle at all times
- ☐ Schedules after dark visits (i.e. winter) ONLY when required by supervisor
- ☐ Avoids and/or recognized potentially dangerous situations in a home visit setting, and knows how to take appropriate action
- ☐ Practices techniques to minimize exposure to contagious diseases
- ☐ Is allowed to request to travel with another staff member when necessary

Other

CHW: _____

Supervisor: _____

H. The CHW sets goals with the client for the next visit

- ☐ Reviews with the client what has been accomplished during the visit
- ☐ Works with client to set goals/objectives for next visit
- ☐ If possible, schedules next visit, time, location, duration and informs client who will call to confirm

Other

Date & Signatures

CHW: _____

Supervisor: _____

I. The CHW appropriately terminates the visit

- ☐ Gives business card(s) and/or business phone number(s) for the client to call with concerns or questions
- ☐ Does not give the client any personal contact information
- ☐ Thanks the client for meeting

Other

Date & Signatures

CHW: _____

Supervisor: _____

J. The CHW understands and demonstrates proper use of First Steps documentation forms and program requirements

Date & Signatures

- ☐ CHW is thoroughly oriented with and demonstrates understanding of how and when to use the FS documentation forms
- ☐ CHW is thoroughly oriented with and demonstrates understanding of compliance with the FS program requirements
- ☐ CHW is able to assist client understand and fill out all forms and questionnaires
- ☐ CHW understands that Supervisor must review and approve by signature all CHW chart notes

Other

CHW: _____

Supervisor: _____

K. The CHW utilizes the Agency's record keeping and document filing requirements

Date & Signatures

- ☐ Documentation about the visit is promptly recorded
- ☐ Forms are filed in the appropriate locations in the client record
- ☐ Copies of forms are appropriately distributed to other locations when indicated

Other

CHW: _____

Supervisor: _____

L. The CHW participates in case conference(s) and/or meetings with supervisor and First Steps Team preceding and following visit(s)

☐ CHW understands value and purpose of interdisciplinary teaming

☐ CHW communicates with supervisor and team members regularly

Other

Date & Signatures

CHW: _____

Supervisor: _____

M. The CHW understands the implementation of the Core Services of First Steps

☐ Minimum Interventions

☐ Basic Health Messages

☐ Linkages, Referrals and Advocacy

Date & Signatures

CHW: _____

Supervisor: _____

Infant Case Manager Qualifications and Job Description

The role of the Infant Case Manager is to assist birth parents and family gain access to needed social and health services in the community. There must be a need by the birth parents for assistance in accessing resources and/or providing care for the infant/family in the household.

Qualifications

A professional member of the Maternity Support Services team.

–OR–

A person with a Bachelor's or Master's degree in a social service related field such as social work, behavioral sciences, psychology, child development, certified home and family life teacher, mental health counselor *plus* one year of experience working in community social services, public health services, crisis intervention, outreach and referral programs or related field.

–OR–

A person with a two year Associate of Arts (AA) degree in social services or related field *plus* two years of full time experience in social services, public health or related field. This paraprofessional must receive monthly clinical supervision by a Master's or Bachelor's prepared person.

Job Description

- Work independently with parenting low-income families who meet specific high-risk criteria
- Competency in assessing needs of clients during home visits
- Knowledge of post pregnancy issues, infant care, parental adjustments
- Collaborate and network with health care providers, DSHS, and other First Steps' agency staff for effective client case conferencing
- Knowledge of medical/social/educational/employment services available in the community
- Effective oral and written communication skills
- Understand and respect cultural differences and diversity
- Possess a basic understanding of the course of addiction

Essential Functions

- Assess risk factors and needs
- Develop an ongoing written ICM plan for care with the family which includes identified needs and outcomes

- Refer and link infant/family with other agencies and programs to meet identified need
- Implement the plan for care to ensure goals are met and documented
- Advocate and assist client to overcome barriers to obtaining services
- Attend *ABCs of First Steps* training and other workshops and/or seminars to enhance skills, knowledge, and abilities

Across All Disciplines

This section provides information on general topics that apply to all members of the MSS/ICM team, including ethics and professionalism, conflicts of interest, cultural competency, personal safety, and home visiting and clinic safety.

Ethics and Professionalism

Ethics are the rules or standards governing the conduct of a person or the members of a specific profession and serve to guide individuals in their daily lives. Ethics are based on principles of correct conduct formed by a combination of influences including culture and personal beliefs, attitudes, desires and laws. Ethics at a minimum include guidance designed to avoid harm to others, respect the rights of others, be honest in word and action, and obey the laws.

Professional Ethics

Professional ethics are agreed upon standards of behavior shared by a group of individuals having the same or similar professions. Individuals need to be familiar with the code of ethics for their profession. Some resources are listed in [Appendix VI, Professional Ethics](#).

Professional Boundaries

Professional boundaries come from ethics and help reduce potential for conflicts of interest. Boundaries make the relationship safe for the client and set the parameters for the services provided. In many cases boundaries are not always clear cut matters of right and wrong and require discussion with the appropriate person within the provider agency. Professional boundaries are especially difficult in smaller communities where providers may also encounter their clients in numerous social settings.

Conflict of Interest

A conflict of interest occurs when there is a divergence between an employee's private interests and their obligations to their employer and clients such that an independent observer might reasonably question whether the employee's professional actions or decisions are determined by considerations of personal gain, financial or otherwise.

The possibilities for conflict of interest are almost limitless and cannot all be covered in this manual. All MSS/ICM agencies shall have a method to educate staff and review potential conflicts of interest for the agency and employees or contractors. Employees and contractors are expected to conduct themselves at all times with the highest ethical standards in a manner which will bear the closest scrutiny, and are responsible for seeking guidance before embarking on activities which might be questionable.

Cultural Competency

MSS/ICM services shall be delivered in a culturally competent manner. The provider agency and staff are expected to demonstrate the knowledge and skills necessary to serve clients of diverse ethnic, cultural, religious and racial backgrounds.

“To be culturally competent doesn’t mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world.”²

See [Cultural Competency Resources](#) in [Appendix VI](#) for additional information.

Personal Safety

Safety is always a concern, whether you are visiting a family’s home, going to work, or running errands. Here are some general suggestions for safety:

- Carefully map a route to your destination and make sure someone else knows your destination route and anticipated arrival/return time.
- Always use your seatbelt while traveling.
- Make sure your vehicle is in good working order and that you have adequate gasoline.
- Know how to change a flat tire. Be sure you have air in your spare tire and that all pieces of your jack are present.
- Lock and secure your vehicle at all times.
- Carry a fully-charged cellular phone along with the family’s phone number and emergency phone numbers.



In remote locations, cell phones are unlikely to function and you may need to carry a two-way radio device.

- When you arrive at your destination, lock items of value out of sight, such as in the trunk of the vehicle. Purses, backpacks, or other unnecessary items should not be taken into the home. These bags often contain items which may be hazardous in small hands, for example, medications, cosmetics, batteries from calculators, coins, and personal defense items such as pepper-based sprays, or knives.
- When walking on a street or sidewalk, stand tall, do not make prolonged eye contact, look over passerby heads, do not smile at strangers, and walk purposefully, even if lost.

Home Visiting and Clinic Safety

Safety issues are not a concern with the majority of clients and should not interfere with a successful home or community MSS/ICM visit. Usually, common sense is the overriding principle of self-protection and behavior. Constant awareness of your surroundings and access to

² Okokon O. Udo PhD, Integrative Health and Wellness, Northwestern Health Sciences University

emergency contact numbers will assist you in avoiding unsafe and potentially unsafe conditions and circumstances.

The purpose of the following guidelines is to direct you toward safe behaviors and activities to be conducted before and during a home/community visit.

Safety precautions before a home visit:

Safety training

Personal safety should be taken seriously. Training should include information on agency safety policies and procedures, personal awareness, risk assessment, relevant interview techniques. Ask your local law enforcement authorities about speakers or available literature to help learn more about staying safe while conducting home visits in unfamiliar neighborhoods or high-crime areas.

Violence Risk Assessment

Regularly review the risk for violence in your area. It has been shown that the best predictors of violence in those with mental disorder *are the same* as those for the rest of the population: they include previous violence, poor parenting, and criminality within the family. Before agreeing to see any client with a history of active acute mental illness, it is important to assess the risk of that patient being violent and ensure that the home visitor is not exposing themselves to danger.

The risk factors for short-term prediction of violence are outlined below:

Risk factors for short-term prediction of violence

Demographic and personal history

Youth, male

A history of violence

Recent threats of violence

Belonging to a subculture where violence is prevalent

Clinical variables

Alcohol or other substance misuse

Symptoms of schizophrenia or mania, especially if there are:

- Delusions or hallucinations focused on an individual
- Specific preoccupation with violence
- Delusions of control with a violent theme
- Signs of agitation, excitement, overt hostility or suspiciousness
- Issues of poor compliance with treatment
- Antisocial, explosive or impulsive personality traits

Situational factors

Lack of social support

Immediate availability of a weapon

Personal information

Take precautions to prevent personal information from becoming available to clients. Information such as home address, telephone number, marital status and names of family members may be misused and facilitate harassment or stalking. Avoid calling clients from homes or cell phone unless personal numbers are blocked to reduce the chances of clients or family members acquiring staff personal telephone numbers.

Transportation

Staff should avoid transporting clients in any vehicle (this may also be agency policy). Always use reliable transportation that is well-fueled. In addition, staff members should have on file at the agency the make, model, and license plate number of the vehicle they are using.

Professional Attire

Professional attire represents who you are and the services you are delivering. Dress in a manner that is professional as well as suitable for the home visiting situation with a nametag as required for the agency.

Schedules

Before leaving for the work day, staff should provide the coordinator or administrative staff with a daily schedule of client visits, to include names and addresses and an estimated time of return to the agency. Also, be sure that someone in your agency knows how to contact you. Routine attempts at home or clinic visits should be set up for daylight hours of a normal service delivery work week. If appointments are needed at a time other than normal working hours, someone within the agency needs to be made aware of staff's destination and how to contact them.

Safety precautions during a home or clinic visit:

- When possible, travel with a partner.
- When possible, alert the destination client or agency that you are coming and have them watch for you.
- Have accurate directions to the street, building, or apartment. If the area is unfamiliar to you, print a map of your route and destination.
- Drive with the windows closed and all car doors locked. Keep your purse or wallet in the trunk.
- As you approach your destination, carefully observe your surroundings. Note the location and activity of people; types and locations of cars; and conditions of buildings (abandoned or heavily congested buildings).

- Before getting out of the car, once again thoroughly check the surroundings. If you feel uneasy, do not get out of the car. Observe the neighborhood and environment, including people who may be loitering nearby and if conditions appear unusual or unsafe, reschedule the visit.
- Park your car in a well lit, heavily traveled area of the street and lock your car. When parking at your destination, park with the car pointing toward the exit so if you need to leave in a hurry, you don't have to turn the car around.
- Do not enter the home if the situation seems questionable (e.g. drunk family members, family quarrel, combativeness, unleashed pets, etc). Have an alternative plan such as postponing visit or meeting client/agency in another designated place. If you need to leave the setting quickly, you may want to say "I am leaving now, I must meet ____", or "I forgot I have an appointment. I have to go."
- Call 911 if in danger or a medical emergency presents itself. Never try to take care of this situation on your own.
- Remain cautious when approaching pets within the home/community setting. They may be territorial and protective of their owners. It may be necessary to ask a family member to confine them briefly while you are completing your assessment and/ or visit.
- Use common walkways in buildings and avoid isolated stairs.
- Always knock on a client's door before entering.
- If relatives or neighbors are or become a safety problem, do not make a visit alone.
- Schedule morning visits in neighborhoods of questionable safety or gang/drug related activity.
- Never go into or stay in a home if personal safety is a question. Always respect your "gut feelings."
- When leaving the client's residence, carry your car keys in your hand.

Communication Techniques

Communication is the key to escalating or deescalating a potential violent situation. The box below contains some techniques that promote positive interactions with all clients:

Safe interviewing techniques

Introduce yourself

Produce identification

Speak clearly without raising your voice

Use the patient's appropriate title and name

Allow plenty of personal space

Avoid prolonged eye contact, especially if the patient is experiencing a

psychotic episode
Avoid turning your back on the patient
Persuade a standing patient to sit down
Do not sit down if the patient remains standing
Use an interpreter if appropriate
Avoid note-taking if the patient is suspicious

In the unfortunate circumstance of being unable to leave in a tense situation, for example if the door is locked, or your escape route is blocked, then using de-escalation techniques is the only option. These are described below:

De-escalation techniques

Try to summon help on your mobile telephone
Maintain an adequate distance
Move towards the door and avoid corners
Explain your intentions to the patient and to any others present
Try to appear calm, self-controlled and coherent
Ensure that your non-verbal communications are non-threatening
Engage in conversation, acknowledge concerns and feelings
Ask for the facts about the problems and encourage reasoning
If a weapon is produced ask for it to be put down rather than handed over

Supervisor's role in promoting safety in the home or clinic setting:

- Review the files of assigned clients for indicators of potential violence.
- Include awareness of any known risks or signs of risk to safety in client referrals to staff.
- Make efforts to provide bridges for relationship building between staff and clients if possible, e.g. have staff members meet clients at the agency; have the staff member present when the client is in the agency for a health care appointment.
- Identify each staff member's training history and experience in violence prevention and identification of risk factors for danger to self and others. Provide safety training for new staff and annual updates for all.
- Review with staff how to conduct a safe home visit, e.g. purpose, structure, clarity of professional role, and care focus.
- Be aware of community areas of risk and times of risk and know where each home visit is taking place.
- Support staff by expressing interest in their responses and experiences and expressing concern for their safe methods of providing care.

- Encourage use of pagers, cellular telephones, and/or two-way radios if possible.

Additional Violence Protective Behaviors

Clinical staff should strive to use the following protective behaviors:

- Listen to your feelings
- Avoid having a negative or hostile attitude
- Avoid body language that conveys fear, negativity, or hostility
- Listen to others—be aware of body language as well as spoken language
- Do not continue treatment or an interview if it feels unsafe—leave
- Do not isolate yourself with a client
- Do not corner yourself without an exit
- Consider gender
- Do not be timid
- Be calm and slow
- Do not be controlling or judgmental
- Set boundaries and keep them
- Respect personal space: no touching, keep a physical distance
- Watch your own posture and body language
- Do not use first names until asked and never use terms of endearment such as “honey” or “sweetie”
- Use your first and last name
- Do not talk about yourself

Information was taken from the following sites:

Personal Safety when Visiting Patients in the Community

<http://apt.rcpsych.org/cgi/content/full/8/3/214>

Home Visit Guidelines

<http://www.uta.edu/nursing/hbk/homevisits.htm>

Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers

www.osha.gov

Preventing Workplace Violence, Seattle-King County Health Department—Field Safety Guide

www.NursingWorld.Org

Charting and Documentation

This section covers First Steps Program Documentation Requirements, effective January 1, 2006.

The goal of documenting First Steps services is for the practitioner to describe the service provided in a concise and efficient format. Documentation needs to support the reimbursement from Medicaid.

General Guidelines

- Documentation should describe what is said and done concisely and efficiently.
- Agencies must have written policies and procedures that guide documentation practices.
- Tracking identified risk factors in a progression from identification to inclusion in the plan for care, to interventions through the visit records, ending with the outcome and discharge summary is essential.
- Documentation should reflect the services being billed by the staff person and be in alignment with their scope of practice and the scope of the program.
- The charting system must have a centralized chart for MSS and ICM clients.
- The MSS mother and infant chart(s) will consist of all documentation for the maternity cycle, including all documentation from all MSS subcontractors.
- The date and duration of a visit must be consistent between the chart documentation and the service billed to Health and Recovery Services Administration.
- Sign notes in keeping with professional standards for licensed mental health counselors, licensed social workers and home health records. *[Refer to WAC 246-810-035 and WAC 246-335-110].*
- Case conferencing must be documented in the client record.

Protecting Confidentiality of Client's Protected Health Information

All information collected in the charts of First Steps clients is considered protected health information (PHI).

First Steps providers must follow state and federal privacy laws and rules regarding the confidentiality of clients' PHI. The First Steps state staff cannot interpret these laws or give legal advice. We can however, make recommendations and provide resource information regarding confidentiality laws.

Separate Charts for Mother and Infant

Although DOH and DSHS cannot regulate how client charts are organized, the First Steps state team highly recommends that separate charts are established for a mother and for her infant during Maternity Support Services and Infant Case Management. This practice is in keeping with the fact that the mother and baby are two distinct clients and it protects the agency, the

practitioner, and the clients. For example, if there is sensitive information about a family member that affects the baby, it should be referenced only (e.g. “see mother’s chart note dated xx-xx-xx”) and not mentioned directly in the baby’s chart. The practice of separate charts for mother and infant also makes it easier for state staff to monitor what services are provided to each client during a site visit.

HIPAA Privacy

For more detailed information on HIPAA privacy:

- Contact your agency’s Privacy Officer since all covered entities must have a Privacy Officer under the HIPAA privacy rules.
- Go to the federal Department of Health and Human Services (DHHS) website: <http://www.hhs.gov/ocr/hipaa/>
- Visit the Revised Code of Washington website: <http://apps.leg.wa.gov/rcw/> <http://www.leg.wa.gov/RCW/index.cfm?fuseaction=chapterdigest&chapter=70.02> and look at RCW 70.02, specifically RCW 70.02.050(1)(e) and .130
- Consult your agency’s lawyers.

Chart Content and Requirements

First Steps agencies must comply with the documentation requirements including the use of required forms except when the agency has an approved exception on file with DOH. There is required chart content for both MSS and ICM. Forms have been created to meet these requirements. Some of the forms are required in the specific format given whereas other forms are suggested formats for documenting the required information.

The First Steps charting system must include:

- Registration information with client demographic and contact Information
- Documentation of client eligibility (PIC#)
- HIPAA-compliant information releases
- Freedom of choice acknowledgement
- Consent for care
- Required screening forms for appropriate period of service:
 - MSS Prenatal New Client
 - MSS Postpartum, Returning or New Client
 - MSS Initial Infant Client
 - ICM, Transition or New Client
- Plan for Care that allows for documentation of the interdisciplinary plan for the individual client’s care

- Protocol for documenting case conferences
- A method for summarizing all Identified Risk Factors, date identified and status
- Methods for documenting evaluations and assessments, both standardized and non-standardized
- A focus on required Core Services
- Required Client Visit Records
- Interventions documented on the required Client Visit Record including:
 - Basic health messages
 - Referrals, advocacy, linkages
 - Use of minimum interventions as protocols for care
- Methods for documenting client progress and/or increasing levels of practitioner support for basic health messages, linkages, and minimum interventions
- Required Outcome and Discharge Summaries
- A place for client's identifying information and date of service on each page (if paper system)
- Clinician signatures and titles according to professional standards (Refer to WAC246-810-035 and WAC246-335-110 for licensed mental health counselors, licensed social workers and home health records)
- Documentation of review by a professional member of the First Steps team for all client services delivered by a Community Health Worker
- Method for tracking units billed

Required Forms

MSS Required Forms

- MSS Prenatal New Client Screening or MSS Client Screening Tool
- MSS Postpartum Screening, New Client or Returning Client
- MSS Initial Infant Screening
- MSS Client Visit Records, with Mother and with Infant
- MSS Service Outcome and Discharge Summaries, Mother and Infant

ICM Required Forms

- ICM Intake DSHS form # 13-658 (revised 6/04)
- ICM Transition Questionnaire or New Client Screening, Infant and Parent

- ICM Client Visit Record, Infant and Parent
- ICM Outcome and Discharge Summary, Infant and Parent

See [Appendix IV, Charting and Documentation](#) for these forms.

Minimal format changes to the required forms to adapt to agency requirements are permissible. For example, check boxes may be changed to yes/no answer. All content must be retained. Please check with your [MSS County Lead](#) before making any changes to the MSS forms and with the Infant Case Management Program Manager for ICM forms.

Agencies may use their own forms/formats for client registration, release of client information, documenting freedom of choice, signature log, plan for care, and case conferencing as long as the content that follows is included.

Description of Required Chart Content

Registration

Demographic and contact information for the client must be documented in the client chart. At a minimum, the following information must be collected:

- Client name
- Date of birth
- Sex (M/F)
- Contact information
- Marital status
- Race (and if applicable, ethnicity and tribal affiliation)
- Primary language spoken
- PIC number and effective date
- Parent or guardian information for minors NOTE: pregnant teens may choose not to share this information [RCW 9.02.100].

Freedom of Choice

The agency must provide a freedom of choice declaration for all clients to read and sign. The declaration must inform the client that services are voluntary [*Section 1915(g)(1) of the Social Security Act*] and she/he is free to choose any First Steps provider for First Steps services regardless of where she/he receives her prenatal, postpartum or pediatric medical care [*Section 1902(a)(23) of the Social Security Act*].

Release of Information

The release of information form is agency-specific. The release of information form must contain an expiration date or an expiration event that relates to the patient or the purpose of the use or

disclosure [RCW 70.02.0303]. It is recommended that the form be approved by the agency's legal counsel to ensure compliance with HIPAA and related rules and regulations.

Each client chart must contain a valid, signed release of information. Separate release forms are required for the mother and infant. During ICM the release of information form for the infant may be signed by either biological parent.

Consent for Care

Each client chart must contain a signed *Consent for Care*. This form is agency-specific. It is recommended that the form be approved by the agency's legal counsel.

Signature Log

All client charts must contain a signature log, with printed names and titles of all staff providing care, and their legal signature. If staff initials are used in the chart, a sample must be included on the signature log.

Client Contact Log

This log is a quick chronological view of contacts with the client.

Client Risk Screening

Use of required screening forms is mandatory at the following points of service: prenatal, postpartum, and ICM. Risk screening provides a method for systematically reviewing and documenting major risk factors, and areas of need or concern for an individual client. The screen is not intended to be an in depth assessment for each risk factor or area of concern or need. Once a risk factor or need/concern is identified, a practitioner may need to evaluate further.

Agencies must ensure that risk screening includes both a process for client input and face to face interaction.

All risk screening forms must be signed and dated in the spaces provided. Agencies are required to provide a method for documenting all risk factors identified during screening. Risk factors may be documented on either the *MSS Plan for Care*, an agency specific service/care plan, a problem/issue page, or on another summary page. Screening may take up to two visits to complete.

During the screening process basic health messages and linkages will be initiated and/or noted for further visits.

If the screening tool is not complete, the provider agency staff will document the reason why, i.e. the client declined, had limited time or it was too soon to share personal information.

MSS Prenatal New Client Screening

There are two options for completing the required prenatal screen. Agencies must use either the *Maternity Support Services Client Screening Tool [DSHS 13-723 (REV. 10/2003)]* or the *MSS Prenatal New Client Screening* (not yet a DSHS numbered form) to conduct and document the initial prenatal new client screen.

MSS Postpartum New Client or Returning Client Screening

Postpartum represents a dramatic change in client status; a new screening form is required to document current status. For clients seen in the prenatal period, use the *MSS Postpartum Returning Client Screening*; for clients newly referred postpartum, use the *MSS Postpartum New Client Screening*.

MSS Initial Infant Screening

The *MSS Initial Infant Screening* collects information regarding the infant. This screening should be completed during the first postpartum visit with the client.

ICM Intake

An *ICM Intake* form [DSHS 13-658 (REV. 06/2004)] must be present in the chart of each ICM client receiving services. This form shows eligibility, and is completed before the ICM screen. If the parent refuses ICM services or the client could not be located, note that on the Intake form and file it according to agency record keeping protocol.

ICM Transition Questionnaire or New Client Screening

For clients who have been seen in MSS and are now eligible for ICM, use the *ICM Transition Questionnaire*. This form provides a chance to review the issues that will be the focus for ICM services. For clients who are newly referred for ICM services (have NOT been MSS clients during this pregnancy), use the *ICM New Client Screening*.

Plan for Care

A plan for the individual client's care must be included in each client's chart. The plan for care must be based upon information from the initial screening visit, and revised as new risk factors are identified or when significant changes occur. A plan for care is required for MSS prenatal, postpartum, and infant services, and for ICM services.

Client Involvement to develop the plan for care is encouraged. Agencies may use the *MSS Plan for Care* and the *ICM Plan for Care* or may use their own versions.

Whether using the *MSS/ICM Plans for Care* or the agency's own format, the following content must be included:

- Identification and prioritization of risk factors, other areas of need or concern identified during the initial screening and any further assessments; date identified should be noted.
- Notation of standard care protocols, such as basic health messages and linkages, and minimum interventions.
- Individual plans for the client.
- Consideration given to client goals.
- Identification of individuals who participated in the care plan development and revisions.
- Cultural and ethnic considerations.

- If a risk factor is identified but will not be part of the plan for care, documentation explaining this decision is required. For example, the risk factor may be a low priority for the client.

The agency must have a process to review the care/service plan at least every trimester of the pregnancy. During ICM the agency must have a process to review the parent and infant plans for care based on the level of client needs and urgency.

Case Conference

For MSS clients, agencies must provide a method for documenting case conferences. The initial case conference and any subsequent updates (or meetings/discussions) must be documented. Case conferences are documented on the contact log or an agency may provide an alternative format, such as a progress note, or an agency-specific form. All decisions and recommendations/plans for care must be documented. All staff present (including by phone) must be identified on the case conference note and on the *Plan for Care* if changes are made to the *Plan for Care*.

Although interdisciplinary case conferences is not required during ICM, there may be instances when infant case managers bring specific cases to their supervisor(s) or First Steps teammate for problem solving to ensure care continuity. These activities should be noted on the plan for care.

Assessment

Assessment or evaluation beyond screening may be necessary in some cases. Assessments may be informal, particularly when conducted by experienced professionals. The informal evaluation/assessment may be documented in one of the following ways:

- Client Visit Record (CVR)
- Contact log
- A format developed by agency

Standardized assessment tools have the advantage of applying standard measurement across clients and being useful for measurement of progress. Examples of standardized assessment tools are the *Beck Depression Scale* and the *Nursing Child Assessment Satellite Training (NCAST)* tools.

Completion of either informal or standardized evaluations/assessments should be noted on the client visit record for that visit with a reference to where in the chart the assessment may be found. Assessment should not duplicate the screening tool but should expand the content area being assessed.

Client Visit Record

The *Client Visit Record (CVR)* form is required for documenting the details of the client visits after the screening is completed and reflect the identified issues from the plan for care. Information documented on the CVR includes follow-up from past visit(s). An example of what would be documented in the follow-up column would be if a client has not followed through on a

previous referral and more support is needed for the client to succeed. **For each visit, only document information about the risk factors addressed during that visit.** The other spaces may be left blank. Significant risk factors must be noted and prioritized on the *Plan for Care*. A very brief note of explanation (e.g. “not addressed due to client’s other priorities”) should be written for any significant risk factor not addressed at the visit.

Please note that there are three separate CVR forms:

- MSS Client Visit Record with Mother
- MSS Client Visit Record with Infant
- ICM Client Visit Record, Section I: Infant and Section II: Parent

On the last page of the CVR is a space for “Next Steps”. In this space note briefly the plan for the immediate future. If significant changes have occurred the *Plan for Care* needs to be updated.

Minimal format changes to the required CVR forms to adapt to agency requirements are permissible. For example, check boxes may be changed to yes or no answers. All content must be retained. Please check with your First Steps DOH State Consultant County Lead before making any changes to the MSS forms. For ICM form changes, contact the First Steps Infant Program Manager at DSHS (see [First Steps State Contacts](#)).

Outcome and Discharge Summaries

For each MSS and ICM client, the *Outcome and Discharge Summary* must be completed. The client’s name, date of discharge and reason for discharge is documented on the top of the form. This form documents progress toward client goals and outcomes of interventions/actions. Discharge comments may be written at the end of each form.

Completion of the Risk Factor #8 and #9 on the *MSS Mother’s Service Outcome and Discharge Summary* fulfills the requirement to bill HRSA for the [Family Planning](#) and [Tobacco Cessation](#) Performance Measures.

There are three separate Outcome and Discharge forms:

- MSS Mother Service Outcome and Discharge Summary
- MSS Infant Service Outcome and Discharge Summary
- ICM Outcome and Discharge Summary, Section I: Infant and Section II: Parent

Electronic Health Records (EHR)

The First Steps Program encourages the use of electronic documentation. Agencies using electronic documentation are expected to adhere to the same standards outlined for paper documentation, with the following exceptions:

- The content of the required forms is required; the format may be changed to facilitate ease of documentation in the electronic format.

- If a paper record is retained, it must contain the information from the required forms, and show how identified risk factors are followed in a progression from identification to inclusion in the plan for care, through visit records, and ending with the outcome and discharge summary. For those risk factors that are identified and not addressed, notation about why they were not addressed should be in the chart.
- If no paper record is retained, the content of the required forms must be documented and the ability to generate a report that meets the standards outlined in this section for monitoring review must exist.

Please check with the [First Steps MSS County Lead](#) with questions about MSS and the [First Steps Infant Program Manager](#) for ICM questions.

Quality Assurance

This section covers quality assurance requirements. All approved Maternity Support Services (MSS) and Infant Case Management (ICM) providers will participate in on-going quality assurance activities, including:

Self Monitoring

Self Monitoring is conducted within the agency and includes a method for reviewing client records for key items or issues. Possible issues include WIC (Women, Infants & Children's Supplemental Food Program) and childbirth education referrals, pediatric provider identification, presence or quality of current service care plan, case conferencing and client feedback or surveys. Self monitoring assists the agency and staff in developing and improving quality services.

Chart Review

Chart Review may be used by state staff to review certain topics or issues such as completion of performance measures, childcare authorization and reviewing staff under an exception or supervision plan. State staff will send a written request via email or letter requesting client records or other documents; the provider will copy and send these back to the requestor. After the review the state staff may respond by email or letter regarding the results of the review.

Technical Assistance Visit

An agency or the state may request a technical assistance visit, allowing for feedback on a program before a formal review occurs. These visits usually involve one or two state staff (depending on the issues and staff availability) and consist of discussion with administrators and program staff and a brief chart review. A summary of the visit will be emailed or mailed to the agency describing strengths and areas for improvement.

Monitoring

A monitoring visit is a formal visit involving two or more state staff. This is not a fiscal audit that is conducted by Medicaid audit staff and focuses more closely on the financial workings of the agency.

The monitoring visit consists of several steps, starting with a self review tool given to the agency prior to the site visit. The site visit starts with a brief discussion with the coordinator and other staff; includes a formal review of client charts, agency documents and policies; and ends with an opportunity for the agency and state staff to review the findings. A written monitoring report including all required corrective action will be sent to the agency. The agency will respond with a plan for addressing the issues. There will be ongoing follow-up until all actions have been satisfactorily completed.

Authority to Review Medical Records

Providers are required to make charts and records available to DSHS, its contractors, and the U.S. Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation [*WAC 388-502-0020 (1.c)*]. The Department of Health is authorized to review client records as per the interagency agreement between DSHS and DOH.

Appendix I: Laws and Regulations Related to First Steps

July 2006

CTRL + click any of the links below for more information on laws and regulations related to First Steps.

[Code of Federal Regulations \(CFR\)](#)

Revised Code of Washington (RCW)

[RCW 74.09.760 - 900](#)

Maternity Care Access Act of 1989

[Washington State Plan under Title XIX of the Social Security Act](#)

Washington Administrative Code (WAC)

[WAC 388-5300-0300 through 0345](#)

Maternity Support Services

[WAC 388-5300-0360 through 0386](#)

Infant Case Management

[WAC 388-5300-0390](#)

Childbirth Education

[WAC 388-5300-0701 through 0730](#)

Chemically Using Pregnant Women (CUP)

[WAC 388-533-1000](#)

First Steps Childcare

More links will be available when the First Steps Manual is converted to the upcoming DSHS electronic manual system.

Appendix II: Billing Instructions

MSS/ICM Billing Instructions: <http://maa.dshs.wa.gov/download/publicationsfees.htm>

Childbirth Education Billing Instructions, Childcare Billing Instructions, and required forms can be found at: <http://fortress.wa.gov/dshs/maa/download/BillingInstructions/FSCC%20BI%2011-15-04.pdf>

Appendix III: State Resources and Contacts

Publications and Resources

Using the DSHS On-line General Store

1. Go to the Department of Printing website at: www.prt.wa.gov
2. Click **General Store**. Register if you are new to the site or sign in. Write down your login for future use.
3. You will be given an option to shop by agency or item type.
4. Click on **Agency**.
5. Click **Department of Social and Health Services, Health and Recovery Services Administration** then **Publications**. You will then have a list of publications by publication number.
6. Select the item you wish and place it in your shopping cart by clicking on the **Add to Cart** button.

VERY IMPORTANT!! YOU MUST click on the **Update Cart** button located below your list of items in your cart. If the button is not visible due to multiple items being in your cart use the scroll buttons on the right to scroll down until it is visible. If you do not click on the **Update Cart** button the program will only see the default number of “1” and that will be all you receive. You may continue shopping and adding items to your cart or you may **Check Out**.

Enter shipping information. Be sure the first time you use the cart you enter your primary shipping information. This will be Address 1 and the default information that will appear each time you check out.

You may add other addresses by selecting **New Address** in the **Select Address** window and filling in the information. Write down what the new address number is and you can have it automatically filled in by choosing that address number. Then click the **Total** button.

The preferred method of ordering is online through the Department of Printing’s General Store. You may also send orders by email to fulfillment@prt.wa.gov, by phone at 360-586-6360 or fax at 360-586-8831. Please order online if at all possible.

Useful web addresses:

- HRSA Publications website: <http://fortress.wa.gov/dshs/maa/CustomerPublications/>
- DSHS Forms: <http://www1.dshs.wa.gov/msa/forms/>
- DOH Publications: A full list of DOH Publications and ordering instructions is available at: http://www3.doh.wa.gov/here/materials/HERE_Materials.aspx

MSS County Lead and Contact Information

County	MSS Contact	Phone
Adams	Kathi LLoyd	(360) 236-3552
Asotin	Kathi LLoyd	(360) 236-3552
Benton-Franklin	Kathi LLoyd	(360) 236-3552
Chelan-Douglas	Cynthia Huskey	(360) 236-3599
Clallam	Cynthia Huskey	(360) 236-3599
Clark	Diane Bailey	(360) 236-3580
Columbia	Kathi LLoyd	(360) 236-3552
Cowlitz	Diane Bailey	(360) 236-3580
Garfield	Kathi LLoyd	(360) 236-3552
Grant	Cynthia Huskey	(360) 236-3599
Grays Harbor	Cynthia Huskey	(360) 236-3599
Island	Becky Peters	(360) 236-3532
Jefferson	Cynthia Huskey	(360) 236-3599
King	Becky Peters	(360) 236-3532
Kitsap	Cynthia Huskey	(360) 236-3599
Kittitas	Cynthia Huskey	(360) 236-3599
Klickitat	Diane Bailey	(360) 236-3580
Lewis	Diane Bailey	(360) 236-3580
Lincoln	Kathi LLoyd	(360) 236-3552
Mason	Cynthia Huskey	(360) 236-3599
Northeast Tri Counties(Ferry,	Kathi LLoyd	(360) 236-3552

Pend Oreille, Stevens)		
Okanogan	Cynthia Huskey	(360) 236-3599
Pacific	Cynthia Huskey	(360) 236-3599
Pierce	Diane Bailey	(360) 236-3580
San Juan	Becky Peters	(360) 236-3532
Skagit	Becky Peters	(360) 236-3532
Skamania	Diane Bailey	(360) 236-3580
Snohomish	Becky Peters	(360) 236-3532
Spokane	Kathi LLoyd	(360) 236-3552
Thurston	Diane Bailey	(360) 236-3580
Tribal Agencies & Issues	Becky Peters	(360) 236-3532
Wahkiakum	Diane Bailey	(360) 236-3580
Walla Walla	Kathi LLoyd	(360) 236-3552
Whatcom	Becky Peters	(360) 236-3532
Whitman	Kathi LLoyd	(360) 236-3552
Yakima	Diane Bailey	(360) 236-3580

ICM Program Manager, All Counties

Maureen (Mo) Lally, Health and Recovery Services, DSHS, (360)725-1655

First Steps/Family Planning/CSO Regional Program Managers

Region	Contact Information
Region 1 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman Counties)	Jason Luoto 509-227-2866 luotoje@dshs.wa.gov
Region 2 (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla and Yakima Counties)	Yolanda McGrann 509-225-7943 mcgray@dshs.wa.gov
Region 3 (Island, San Juan, Skagit, Snohomish and Whatcom Counties)	Sue Chance 360-658-6878 chancesa@dshs.wa.gov
Region 4 (King County)	Nick Clemenson 206-272-2154 clemen@dshs.wa.gov
Region 5 (Pierce and Kitsap Counties)	Leslie Harmon 253-476-7034 harmonl@dshs.wa.gov
Region 6 (Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties)	Kim Shidell 360-725-4806 shidek@dshs.wa.gov

DASA Regional Administrators*(Revised 05/16/2006)*

Name/Address/Phone	Counties Served	Federally Recognized Tribes
<p>Ray Antonsen – Region 1</p> <p>Division of Alcohol and Substance Abuse 1212 N. Washington, Ste. 207 Spokane, Washington 99201-2403 (509) 329-3733; FAX (509) 329-3728 E-Mail Address: antonrf@dshs.wa.gov Julia Greeson, Regional Prevention Manager Cyndi Beemer, Regional Treatment Manager</p>	<p>Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Whitman</p>	<p>Colville Confederated Tribes, Kalispel Tribe of Indians, Spokane Tribe of Indians</p>
<p>Ella Hanks – Region 2</p> <p>Division of Alcohol and Substance Abuse 1002 North 16th, Third Floor (Mail Stop B39-6) Post Office Box 9428 Yakima, Washington 98909 (509) 225-6196; FAX (509) 454-7611 TTY (509) 575-2009 E-Mail Address: hanksem@dshs.wa.gov Stephanie Wise, Regional Prevention Manager Eric Larson, Regional Treatment Manager</p>	<p>Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Yakima</p>	<p>Yakama Indian Nation</p>

<p>Dick Jones – Region 3</p> <p>Division of Alcohol and Substance Abuse 16710 Smokey Point Blvd., Ste. 103 Arlington, Washington 98223 (360) 658-6893; FAX (360) 651-6124 TTY (To be assigned.) E-Mail Address: jonesde1@dshs.wa.gov Shelli Young, Regional Prevention Manager MeLinda Trujillo, Regional Treatment Manager</p>	<p>Island, San Juan, Skagit, Snohomish, Whatcom</p>	<p>Lummi, Nooksack, Samish Nation, Sauk Suiattle, Stillaguamish, Swinomish, Tulalip, Upper Skagit</p>
<p>Harvey Funai – Region 4</p> <p>Division of Alcohol and Substance Abuse Region 4 CSD (Mail Stop N17-18) 400 Mercer Street, Suite 600 Seattle, Washington 98109-4641 (206) 272-2156; FAX (206) 216-3174 TTY (206) 298-4408 E-Mail Address: funaihm@dshs.wa.gov Vacant, Regional Prevention Manager Bob Leonard, Regional Treatment Manager</p>	<p>King</p>	<p>Muckleshoot, Snoqualmie</p>
<p>Earl Long – Region 5</p> <p>Division of Alcohol and Substance Abuse 2121 South State Street (MS: N27-11) Tacoma, Washington 98405-2808 (253) 983-6066; FAX (253) 983-6062 TTY (253) 476-7002 E-Mail Address: longea@dshs.wa.gov Steve Brown, Regional Prevention Manager Miae Christofferson, Regional Treatment Manager</p>	<p>Kitsap, Pierce</p>	<p>Port Gamble S'Klallam, Puyallup, Suquamish</p>

<p>Tiffany Villines – Region 6</p> <p>Division of Alcohol and Substance Abuse</p> <p>Post Office Box 45330 (MS: 45330)</p> <p>Olympia, Washington 98504-5330</p> <p>(360) 725-3726; FAX (360) 438-8078</p> <p>TTY Relay Operator 1-800-833-6388 (-6384 voice)</p> <p>E-Mail Address: villitf@dshs.wa.gov</p> <p>Heidi Dodd, Regional Prevention Manager</p> <p>Ruth Leonard, Regional Treatment Manager</p>	<p>Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston, Wahkiakum</p>	<p>Confederated Tribes of Chehalis, Cowlitz, Hoh, Jamestown S’Kallam, Lower Elwha Klallam, Makah, Nisqually, Quileute, Quinault Nation, Shoalwater Bay, Skokomish, Squaxin Island</p>
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CPS Regional Contacts

June 2006

Region	Contact Information
Region 1	Nicole LaBelle 1313 N. Atlantic St. Ste. 2000 (MS 32-21) 509-363-3321 Spokane, WA 99201-9995 Lani300@dshs.wa.gov
Region 2	Roberto Rodriguez 2010 Yakima Valley Hwy. Ste. F-2 (MS B54-3) 509-836-5753 Roro300@dshs.wa.gov
Region 3	Patty Turner 1550 - 4th Ave. S. (MS TB-12A) Seattle, WA 98134-1510 206-516-7639 plturner@dshs.wa.gov
Region 4	Jeff Norman 100 W. Harrison, Ste. 400 (N17-21) Seattle, WA 98119 206-691-2520 Norj300@dshs.wa.gov
Region 5	Bob Palmer 1949 S.State. St. (MS N27-1) Tacoma, WA 98405 253-983-6249 Paro300@dshs.wa.gov
Region 6	Edith Hitchings 6840 Capitol Blvd. Tumwater, WA 98501-6714 360-725-6757 Hied300@dshs.wa.gov

First Steps State Contacts by Agency and Topic

Department of Health Maternal and Infant Health P.O. Box 47880 Olympia, WA 98504-7880 FAX (360) 586-7868	Department of Social and Health Services Health and Recovery Services Administration P.O. Box 45530 Olympia, WA 98504-5530 FAX (360) 753-7315
Managers	
Kathy Chapman, RN, MN (360) 236-3968 kathy.chapman2@doh.wa.gov	Nancy Anderson, M.D. (360) 725-1751 anderna@dshs.wa.gov
Program Staff	
TBA MSS Coordinator (360) 236-3967 TBA	Lenore Lawrence, MS Program Manager, First Steps Clearinghouse (360) 725-1666 lawrele@dshs.wa.gov
Diane Bailey, MN Community Health Nurse Consultant (360) 236-3580 diane.bailey@doh.wa.gov	Maureen Lally, MSW Program Manager, Infant Case Management (360) 725-1655 lallyma@dshs.wa.gov
Kathi LLOYD, MPA Health Education Consultant Community Health Worker/Childbirth Education (360) 236-3552 kathi.lloyd@doh.wa.gov	First Steps Childcare FAX: (360) 586-1951 1-888-889-7514 firststeps@dshs.wa.gov
Cynthia Huskey, RD, CD Nutrition Consultant (360) 236-3599 cynthia.huskey@doh.wa.gov	Cathy Hewins Program Coordinator (360) 725-1654 hewincj@dshs.wa.gov
Becky Peters, MA, LMHC Behavioral Health Consultant (360) 236-3532 rebecca.peters@doh.wa.gov	Sara Hensley Program Assistance (360) 725-1710 henslsm@dshs.wa.gov

Support Staff	
Kelly Finney 360) 236-3538 kelly.finney@doh.wa.gov	Talia Baker (360) 725-1661 bakert1@dshs.wa.gov

Appendix IV: Charting and Documentation Forms

In the Microsoft Word version of this manual, double-click on the icon of the form under the document name to open a copy you can view, save, or print.

If you are viewing a PDF version of this manual, please open the separate PDF file “Appendix IV: Charting and Documentation” for a document containing all of these forms.

Provider Guide to Forms



Provider Guide to
Forms - Final 07-06

Business Forms

Client Registration Form



Client Registration
Form - Final 08-05

Freedom of Choice



Freedom of Choice
- Final 08-05

Service Unit Tracking



MSS-ICM Service
Tracking - Final 08-05

Billing Info for Agency Business Office



Billing Info for
Agency Business Offi

Clinical Charting Forms: Format not Required

Signature Log



Signature Log - Final
08-05

Client Contact Log



Client Contact
Log-Final 08-05

MSS/ICM Client Contact Log & Service Tracking



MSS/ICM Client
Contact Log & Service

MSS Plan for MOTHER'S Care



MSS Plan For
MOTHER'S Care-Final

MSS Plan for INFANT'S Care

ICM Plan for Care



MSS Plan For
INFANTS Care-Final (



ICM Plan for Care -
Final 05-31-06

Clinical Charting Forms: Required

MSS Prenatal New Client Screening



MSS Prenatal New
Client Screening-Final

MSS Postpartum New Client Screening



MSS PP New Client
Screening-Final 08-05

MSS Initial Infant Screening



MSS Initial Infant
Screening-Final 08-05

MSS Postpartum Returning Client Screening



MSS PP Returning
Client Screening Final

ICM Intake



ICM_Intake_13_658

ICM New Client Screening



ICM New Client
Screening - Final 06-1

ICM Transition Questionnaire



ICM Transition
Questionnaire - Final

ICM Client Visit Record Infant and Parent



ICM Client Visit
Record-Final 07-06

MSS Client Visit Record with Mother



MSS CVR
MOTHER-Final 08-05

MSS Client Visit Record with Infant



MSS CVR
INFANT-Final 08-05

MSS Mother Service Outcome and Discharge Summary



MSS Mother's Serv
Otcn-Dschrg Summar

MSS Infant Service Outcome and Discharge Summary



MSS Infant Serv
Otcn-Dschrg Summar

ICM Infant Outcome and Discharge

Summary Infant and Parent

ICM Service
Outcomes and Discha

Miscellaneous Forms: Not Required Chart Content**MSS Client Questionnaire**

Client
Questionnaire-WELC

First Steps At A Glance Resource List

First Steps At A
Glance Resource List

First Steps Referral to CPS

First Steps referral
form -FINAL- 7 26 06

First Steps Resource List: blank

First Steps Resource
List

Appendix V: Staff Orientation

New Staff Orientation Guidelines

Overview

- Provide Overview of Maternity Access Act of 1989
- Review goals of First Steps

Service Model Delivery System

- Inter-disciplinary team approach to care
- Review rationale for interdisciplinary team
- Describe professional roles and unique contributions of each team member
- Develop a plan for shadowing other team members or interviewing them
- Describe methods of case conferencing

Core Services

- Review required basic health messages
- Information on local linkages
- Education regarding risk factors and minimum interventions

Client Centered Care

- Review the parameters of a “face to face” preventive health care delivery system in the community setting (home or clinic)
- Review basic concepts of Motivational Interviewing and [*Stages of Change*](#) Theory

Discipline Specific Expertise Development

- Provide discipline-specific orientation as indicated
- Review client screening, basic health messages, basic linkages and minimum interventions
- Develop individualized supervision/mentoring/consultation plan
- Determine staff development plan based on individual’s knowledge of maternal child health issues and community health interventions during the maternity cycle and the infant case management eligibility period

Documentation guidelines

- Review billing instructions and other related materials pertinent to the delivery of services, documentation, quality assurance, and reimbursement
- Review instructions for use of charting and documentation tools

- Review client release of information and consent forms and protocols

Community, population served, and resources

- Review information on community resources and other providers
- Describe client population including cultural, ethnic, and religious characteristics and issues of poverty
- Review home visitor and workplace safety

Other

- Review quality assurance activities within Maternity Support Services and Infant Case Management
- Review actual and potential ethical issues found in providing care to the pregnant Medicaid population in the community
- Review transportation, mandatory reporting, DASA, CBE and DASA, confidentiality

Appendix VI: Useful Links

Professional Ethics Links

Professional code of ethics for Dietitians

www.eatright.org

Professional code of ethics for Nurses

<http://www.icn.ch/icncode.pdf>

Professional code of ethics and practice standards for Behavioral Health Specialists

American Counseling Association

www.counseling.org

American Mental Health Counseling Associations

www.amhca.org

ACA Code of Ethics & Standards of Practice

www.cacd.org/codeofethics.html

National Association of Social Workers

www.naswdc.org

NASW Code of Ethics

www.socialworkers.org/pubs/code/

Washington Counseling Association

www.wacounseling.org

Washington Association of Mental Health Counselors

www.wmhca.org

National Association of Perinatal Social Workers

www.napsw.org

American Association for Marriage and Family Therapy

www.aamft.org

Cultural Competency Resources

Providers' Guide to Quality and Culture

<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

Cultural Competency Webpage

<http://cecp.air.org/cultural/>

National Center for Cultural Competency

<http://www.georgetown.edu/research/gucdc/nccc>

Cross Cultural Health Care Program

<http://www.xculture.org>

Office of Minority Health—The Center for Linguistic and Cultural Competence in Health Care

<http://www.omhrc.gov/cultural>

Diversity Rx—Resources for Cross Cultural Health Care

<http://www.diversityrx.org/HTML/WERCCH.htm>

Motivational Interviewing

Motivational Interviewing

<http://www.motivationalinterview.org/training/index.html>

Referrals and Linkages

Publications

Health Education and other publications from the Departments of Health and Social and Health Services can be found at:

http://fortress.wa.gov/dshs/maa/firststeps/ordering_basic_health_education_.htm

Web Based Resources

Additional resources on a wide variety of topics.

http://fortress.wa.gov/dshs/maa/firststeps/web_based_resources.htm

Family Health Hotline

Toll-free phone number and baby book

1-800-322-2588

Appendix VII: Definitions and Acronyms

Definitions

This section contains definitions used in this manual and other related to the Medical Assistance program. The definitions are presented as a guide for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgment. The criteria apply to all providers and contractors.

ADATSA/DASA Assessment Centers—Alcohol and Drug Addiction Treatment and Support Act. DASA is the Division of Alcohol and Substance Abuse. Agencies contracted by DASA to provide chemical dependency assessment for ADATSA clients and pregnant women. Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

Advocacy—Actions taken to support the parent(s) in accessing needed services or goods, and helping parents(s) develop skills to access services.

Agency—An entity qualified and approved by DSHS and DOH to provide First Steps Maternity Support Services and Infant Case Management in the state of Washington [WAC 388-502-0010]

Applicant—A person who has applied for medical assistance.

Assessment—A comprehensive evaluation of an individual's identified risk factor(s) to determine severity and treatment

Authorization requirement—A condition of coverage and reimbursement for specific services or equipment, when required by WAC or billing instructions.

Basic Health Messages—For the purposes of this program, preventative health education messages designed to promote healthy pregnancies, healthy newborns, and healthy parenting during the first year of life. [Refer to WAC 388-533-0315]

Case Conference—See [Interdisciplinary Case Conference](#).

Case Management—Assistance for individuals who are eligible under the Medicaid State Plan to gain access to needed medical, social, educational and other services. [Refer to WAC 388-533-0315] For the purposes of this program, Case Management includes linkage, advocacy and referrals done in a prescribed and accountable manner.

Chemical Dependency—A condition characterized by reliance on psychoactive chemicals. These chemicals include alcohol, marijuana, stimulants such as cocaine and methamphetamine, heroin, and/or other narcotics. Dependency characteristics include: loss of control over the amount and circumstances of use, symptoms of tolerance, physiologic and psychological withdrawal when use is reduced or discontinued, and substantial impairment or endangerment of health, social and economic function

Chemical Use or Substance Abuse—Chemical use means any ingestion of psychoactive chemicals or any pattern of psychoactive chemical use. Use patterns are characterized by

continued use despite knowledge of having persistent or reoccurring social, occupational, psychological or physical problems that are caused by or exacerbated by use.

Childbirth Education (CBE)—A series of educational sessions offered in a group setting and led by an approved instructor that prepare pregnant women and her support person for an upcoming childbirth. Childbirth Education providers are approved separately from Maternity Support Services and Infant Case Management providers although some MSS/ICM providers are also CBE providers.

Childcare—

- **DASA**—(Division of Alcohol and Substance Abuse) The childcare for women attending outpatient alcohol and drug treatment services that may be provided through the treatment facility.
- **First Steps Childcare** funded through the First Steps Program for the care of children of pregnant or post-pregnant women who are attending appointments for Medicaid-covered services, pregnant women on physician ordered bed rest and for visits to the neonatal intensive care unit (NICU) after delivery. [*Refer to WAC 388-533-0315*]

Child Protective Services (CPS)—The program within the Division of Child and Family Services authorized by statute (*RCW 26.44*) to receive and investigate referrals of child abuse, neglect, and exploitation.

Children's Coordinated Services (CCS)—The federal Title V program for children with special health care needs.

Children with Special Health Care Needs (CSHCN)—Title V (federally funded) program for children with special health care needs.

Client—An individual who has been determined eligible to receive medical or health care services under any H&RSA program.

Client Tracking Activities—A method for identifying eligible clients and tracking who is providing First Steps services to each client with the intent of reducing duplication and improving quality of care through better coordination. Each county had developed or is working on a method to improve client tracking within their county.

Clinical Supervision—Monitoring the clinical work performance of staff or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it shall occur regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care including but not limited to review of assessment, diagnostic formulation, treatment planning, progress towards completion of care , identification of barriers to care, continuation of service and authorization of care [*Title XIX state plan, attachment 3.1-A, p. 46*].

Code of Federal Regulations (CFR)—The codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation.

Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis.
<http://www.gpoaccess.gov/cfr/about.html>

Community and Family Health (CFH)—The division within the state Department of Health whose mission is to improve the health and well-being of Washington residents, with a special focus on infants, children, youth, pregnant woman, and prospective parents. *[Refer to WAC 388-533-0315]*

Community Services Office (CSO)—An office of DSHS that administers social and health services at the community level. Eligibility for Medicaid is also determined at the client's local CSO. *[Refer to WAC 388-500-0005]*

Consultation—The practice of conferring with other professionals to share knowledge and problem-solve with the intent of providing the best possible care to clients. *[WAC 388-533.0315]*

Core Provider Agreement—The basic contract between H&RSA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs. *[WAC 388-502.0010]*

Core Services—Services that provide the framework for interdisciplinary client –centered maternity support services that include client screening, basic health messages, linkages and minimum interventions. For Infant Case Management core services include screening, linkage, advocacy and referral based on the needs of the infant and family to increase the family's self sufficiency in accessing needed services. *[WAC 388-533-0315]*.

Corrective Action Plan—A written plan for the Agency prepared by the First Steps Consultation/Management Team that addresses how and when any problem(s) will be corrected. It must be signed and dated with a copy sent to DOH.

Covered Services—Those services as set forth in WAC 388-533-0330 and WAC 388-533-0380.

Cultural Competency—Services that are delivered in a manner that is appropriate to the culture of the client and their family and improves communication and awareness and builds competencies to strengthen family functioning. Services must be for the benefit of attaining the goals identified for the individual in their individual service plan (Title XIX state plan, attachment 3.1-A, p. 48).

Department of Health (DOH)—The agency whose mission is to protect and improve the health of people in Washington State. *[WAC 388-533-0315]*

Department of Social and Health Services (DSHS) or "The Department"—The state agency that administers social and health services programs for the state of Washington. *[WAC 388-533-0315]*

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)—A program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid. *[WAC 388-500-0005]*

EPSDT Provider—(1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as a EPSDT provider; or (2) a dentist, dental hygienist, audiologist,

optometrist or ophthalmologist who is an enrolled Medical Assistance provider and performs all or one component of the ESPDT screening.

Explanation of Benefits (EOB)—A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Federal Aid—Matching funds from the federal government received by the state for medical assistance programs.

First Steps—The name given to the comprehensive services authorized in the 1989 Maternity Care Access Act.

First Steps Childcare—See [Childcare](#).

First Steps Consultation Team (FSCT)—The state level First Steps Team from both DSHS and DOH that consists of the First Steps Infant Program Manager, the First Steps Clearinghouse Program Manager, First Steps Coordinator, Community Health Nurse Consultant, Behavioral Health Consultant, Nutrition Consultant, and the Community Health Worker/Childbirth Education Consultant. The First Steps Consultation team provides technical assistance to programs and professional disciplines; develops protocols and guidelines for service delivery; monitors data related to service delivery and program outcomes; and conducts site visits to Integrated MSS/ICM agencies for monitoring purposes.

First Steps DOH/MSS County Lead—A member of the FSCT from DOH who, in addition to having a discipline specific area of expertise, serves as the primary MSS contact person for specific counties.

First Steps Management Team (FSMT)—The First Steps Consultation Team and the managers from DSHS/Health and Recovery Services Administration/Division of Program Support and DOH/Maternal and Child Health/Maternal and Infant Health.

First Steps Manual—The document produced by the FSCT that provides guidance for the First Steps program including detailed description of the Core Services, staff requirements, information on billable services and related rules and regulations.

First Steps Quality of Care Policy—Policy that establishes effective and equitable methods for the Department of Social and Health Services (DSHS) to use to ensure providers comply with the terms of any contract or agreement with Health and Service Services Administration fee-for-service First Steps program.

Health and Recovery Services Administration (HRSA)—The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance program (SCHIP), Title XVI, and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Home Visit—Services delivered in the client's place of residence or other setting (as in the hospital), if the Maternity Support Services and Infant Case Management provider is not located on the hospital campus. If a visit is not possible, due to an unsafe place of residence or a

potential problem with client confidentiality, an alternative site may be billed as a home visit. [Refer to WAC 388-533-0325]

Hospital Visit—For the purpose of this program, services that are delivered in the hospital or on the hospital campus. To qualify as a hospital visit the provider agency's place of business cannot be located on the hospital campus. The place of service code used on the HCFA-1500 is 21. Services are reimbursed at the same rate as home visits. Provider agencies located on a hospital campus use place of service code 11 and are reimbursed at the office visit rate.

Infant Case Management (ICM)—Case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle and up to the infant's first birthday [WAC 388-533-0365]. The goal of ICM is to improve the birth parents' self-sufficiency to access existing community resources to meet immediate needs. [CFR 42.431/440/441/447]

Interagency Agreement—A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS/ICM clients) [WAC 388-533-0315].

Interdisciplinary Case Conference—The mechanism by which the interdisciplinary team communicates. The purpose of the case conference is to coordinate client services, clarify client issues, review discipline specific interventions and progress towards desired outcomes, revise the plan for care as needed, reduce duplication of services and maximize effective use of the discipline expertise.

Interdisciplinary Team—Members from different professions and occupations that work closely together and communicate frequently (case conferencing) to optimize care for the client (pregnant woman and infant). Each team member contributes specialized knowledge, skills, and experience to support and augments the contributions of the other team members [WAC 388-533-0315]. In the First Steps Maternity Support Services program, the interdisciplinary team consists of a community health nurse (CHN), a behavioral health specialist (BHS), registered dietitian (RD), and in some cases a community health worker (CHW). All team members must meet the qualifications for the position described in the First Steps Manual.

Linkages—Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services. [WAC 388-533-0315]

Local Match—Nonfederal funds provided by local entities to match the federal Title XIX funds provided for a given program.

Managed Care—A comprehensive system of medical and health care delivery including preventive, primary specialty, and ancillary health services. These services are provided through a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-538-050]

Maternal and Infant Health (MIH)—A section within the state Department of Health. MIH works collaboratively with DSHS to provide clinical consultation, oversight and monitoring of the Maternity Support Services / Infant Case Management program. [WAC 388-533-0315]

Maternity Cycle—Eligibility period for MSS that begins during pregnancy and continues to the end of the month in which the 60th day after the end of the pregnancy. [WAC 388-533-0315]

Maternity Support Services (MSS)—Preventive health services for pregnant/post pregnant women including: screening, professional observation, assessment, education, intervention, and case management. MSS services are provided by an interdisciplinary team consisting of, at a minimum, a community health nurse (CHN), a registered dietitian (RD), and a behavioral health specialist (BHS). Additional MSS services may be provided by community health workers (CHW). [WAC 388-533-0315]

Maximum Allowable—The maximum dollar amount HRSA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid—The state and federally funded Title XIX program under which medical care is provided to persons eligible for one or both of the following:

- Categorically needy program
- Medically needy program

Medical Identification Card—The document HRSA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary—Services that are reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly "course of treatment" available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all [WAC 388-500-0005].

Minimum Interventions—Defined levels of client assessment, education, interventions and outcome evaluation for specific risk factors found in client screening for MSS/ICM services, or identified during ongoing services. [WAC 388-533-0315]

Office Visit—Services are delivered in an office or an alternate formal setting at the agency or one of its off-campus sites. (for example: WIC clinic, satellite office, clinic site, mobile office).

Patient Identification Code (PIC)—An alphanumeric code assigned to each HRSA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birth date, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Performance Measure—An indicator used to measure the results of a focused intervention or initiative. [WAC 388-533-0315]

Personal Information—Information identifiable to any person, including but not limited to information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, drivers license numbers, other identifying numbers, and any financial identifiers.

Plan for Care—The written plan for treatment that must be developed and maintained throughout the eligibility period for each client in the Maternity Support Services /Infant Case Management programs. The plan for care must be based on client choice and initial screening and revised as circumstances change or new risk factor is identified. The plan is required for MSS and ICM services. [Refer to WAC 388-533-0315]

Post pregnancy period—Begins on the last day of the pregnancy and extends through the end of the month in which the 60th day period following termination of pregnancy ends. (CFR42.440.210(3))

Provider OR Provider Agency—A public or private social service, health or education agency employing qualified professional staff and approved by the First Steps Management Team (FSMT) to provide services to eligible clients.

Provider number—An identification number issued to providers who have a signed agreement with H&RSA.

Psychoactive chemicals—Chemicals, including alcoholic beverages, controlled substances, prescription drugs, and over-the-counter (OTC) drugs, which affect mood and/or behavior. Nicotine and food are not considered psychoactive chemicals.

RCW—Revised Code of Washington. All references in this document to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at <http://apps.leg.wa.gov/rcw/>

Referral—Providing information to the client that will assist them in receiving medical, social, educational, or other services.

Regulation—Any federal, state, or local regulation, rule or ordinance.

Remittance and Status Report—A report produced by the Medicaid Management Information System (MMIS), HRSA's claims processing system that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW)—Washington State laws [http://wsl.leg.wa.gov/wsladm/rcw.htm].

Risk factors—Biological, psychological or social factors that could lead to negative pregnancy or parenting outcomes. The MSS and ICM program design identifies specific risk factors and corresponding minimum interventions [WAC 388-533-0315].

Screening—A method used to identify an individual's potential risk factors. It is an attempt to find out a little information about a number of potential risk factors.

Service Plan—The written plan of care that must be developed and maintained throughout the eligibility period for each client in the MSS and ICM programs [WAC 388-533-0315]. In the documentation requirements, “service plan” is referred to as the “plan for care.”

Staff—For the purposes of this program, the personnel employed by MSS/ICM providers. [Refer to WAC 388-533-0315]

Standard of Care—What any reasonably prudent health care provider would do in the same or similar circumstances.

State Children’s Health Insurance Program (SCHIP)—A state-funded full-scope health program for children 17 years of age and younger who are not eligible for a federal health program.

Subcontractor—An individual or agency that has contracted with a primary MSS/ICM provider to provide services to MSS/ICM clients. This individual or agency must be informed of, and comply with, all regulations contained in the First Steps Assurances as they pertain to service delivery to the MSS/ICM client.

Substance abuse—See [Chemical Use](#)

Supervision—See [Clinical Supervision](#)

Third Party—Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

Title XIX—The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Unit of service—Fifteen minutes of one-to-one service delivered face-to-face. [WAC 388-533-0315]

Usual and customary charge—The fee that the provider typically charges the general public for the product or service. [WAC 388-500-0005]

Washington Administrative Code (WAC)—Codified rules of the state of Washington. [http://www.mrsc.org/wac.htm]

WIC (Women, Infant, and Children)—A federal supplemental nutrition program for women, infants, and children.

Commonly Used Acronyms

Acronym Description

AAG.....	Assistant Attorney General
ACES	Automated Client Eligibility System
ADATSA	Alcohol and Drug Addiction Treatment and Support Act
AEM.....	Alien Emergency Medical
AIDS	Acquired Immune Deficiency Syndrome
ARNP.....	Advanced Registered Nurse Practitioner
ARS.....	Alternate Response System
BH Plus	Basic Health Plus
BI.....	Billing Instructions
CBE.....	Childbirth Education
CCF	Congregate Care Facility
CDC	Center for Disease Control
CHC	Community Health Clinic
CHW	Community Health Worker
CMHC.....	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services (Federal)
CNP.....	Categorically Needy Program
CPS	Child Protective Services
CSO.....	Community Services Office
CUP.....	Chemically-Using Pregnant Woman
CVR	Client Visit Record
DASA.....	Division of Alcohol and Substance Abuse (DSHS—HRSA)
DCFS.....	Division of Child and Family Services (DSHS—Children’s Admin)
DCS	Division of Child Support (DSHS—ESA)
DCS.....	Division of Customer Support (DSHS—HRSA)
DDD.....	Division of Developmental Disabilities (DSHS—ADSA)
DHHS.....	Department of Health and Human Service (Federal)
DMM.....	Division of Medical Management (DSHS—MAA)

DOB	Date of Birth
DOD	Date of Death
DOH	Department of Health (state)
DPS	Division of Program Support (DSHS—MAA)
DRG	Diagnosis Related Group
DSHS	Department of Social and Health Services (state)
EMC	Electronic Media Claims
EOB	Explanation of Benefits
EPA	Expedited Prior Authorization
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ESA	Economic Services Administration (DSHS)
FFS	Fee-for-Service
FICA	Federal Insurance Contribution Act (Federal—Social Security)
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSCT	First Steps Consultation Team
FSMT	First Steps Management Team
FSS	Financial Services Specialist
GA-X	General Assistance—Unemployable with Expedited Categorically Needy
HCA	Health Care Authority (State)
HCFA	Health Care Financing Administration (Federal—now CMS)
HRSA	Health and Recovery Services Administration
HIPAA	Health Insurance Portability and Accountability Act
ICC	Interdisciplinary Case Conferencing
ICF	Intermediate Care Facility
ICM	Infant Case Management
IDG	Interdisciplinary Group
IHS	Indian Health Services
ITEIP	Infant Toddler Early Intervention Program
LEP	Limited English Proficiency
MAA	Medical Assistance Administration (now HRSA)

MEDS	Medical Eligibility Determination Section (DSHS—HRSA—DCS)
MEV	Medical Eligibility Verification
MHD	Mental Health Division (DSHS—HRSA)
MMIS	Medicaid Management Information System (now Provider One)
MNP	Medically Needy Program
MSS	Maternity Support Services
PA	Prior Authorization
PCCM	Primary Care Case Manager/Management
PCP	Primary Care Provider
PIC	Patient Identification Code
POC	Plan of Care
POS	Place of Service
PRU	Provider Relations Unit (DSHS—HRSA—DCS)
RA	Remittance Advice
RCW	Revised Code of Washington
RD	Registered Dietitian
RFP	Request for Proposal
RHC	Rural Health Clinic
RSN	Regional Support Network
SCHIP	State Children’s Health Insurance Program
SSPS	Social Service Payment System
TANF	Temporary Assistance to Needy Families
TDD	Telecommunications Device for the Deaf
TISS	Transportation & Interpreter Services Section
TPL	Third Party Liability
WAC	Washington Administrative Code
WSMA	Washington State Medical Association

Appendix VIII: Provider Requirements

This section is under development. The assurances and guidelines are being reviewed and will be rewritten in the months to come to provide clearer explanations of program requirements.

Documentation Requirements

The First Steps Program has developed requirements for documenting services to First Steps MSS and ICM clients. Documentation requirements became effective for MSS on January 1, 2006 and ICM on September 1, 2006. The documentation requirements for the First Steps Program include a combination of required forms, required content, and required agency policies. Please see [Charting and Documentation](#) of the First Steps Manual for information on required chart content and [Appendix IV](#) for information related to specific forms.

Electronic Medical/Health Records

Please note policies for electronic medical records in the above referenced sections of the First Steps Manual. This is a new and evolving area; the policies are intended to provide some latitude, while retaining some standardization of information collected.

Timeline:

- By January 1, 2006, MSS Documentation Requirements effective for all First Steps agencies
- By September 1, 2006 ICM Documentation Requirements effective for all First Steps agencies
- Target for a Quality Improvement Review is January 2007

Documentation Exception and Time Extension Process:

If you wish to request a *time extension*, meaning you plan to adopt all the required forms but you cannot meet the January 1, 2006 deadline, send a letter or email to your county lead explaining your situation and when you will be able to comply, and the process you are using to make progress toward compliance.

If you wish to request an *exception to using the required forms*, please follow these three steps:

1. Send a letter or email to your county lead for MSS forms and to the ICM Program Manager for ICM forms. You must be able to demonstrate a compelling business reason(s) for needing an exception. Your reasons must demonstrate a hardship that exceeds the normal challenges of adjusting to changes.
2. Provide an explanation of how you intend to meet all the requirements with your proposed forms or system. Include samples of what you intend to use as a substitute for the required forms. You must submit the forms or report even if you're planning to use forms that other agencies are using.

3. Include a key (like a cross-reference or crosswalk) showing how the charting content elements on the required forms can be found on the substitute forms or a system report.

Once all of this information is received, the Exceptions Committee will review each request and will respond to you with a decision within 14 business days. The purpose of this is to limit exceptions to those agencies who can demonstrate that adoption will create a significant disruption to their business and to evaluate requests using a consistent and objective process. There is no guarantee that requesting an exception will result in it being granted. Remember, even if you propose to use different forms or a different system, you must still be able to provide all the information that is in the required forms.

Guidelines

Documents to assist providers to better understand MSS/ICM program requirements in regards to specific topics.

New Providers

Representatives from the Department of Health (DOH) and the Department of Social and Health Services Medical Assistance Administration (MAA) recruit and approve new providers using the following criteria:

- Services must be delivered in an area of geographic need as determined by DOH/DSHS program guidelines and most current data related to program access and capacity within a geographical area.
- Recent closure or major reduction in service capacity of a local MSS/ICM agency has created a need for additional resources to maintain access to services.
- The applying agency has demonstrated an ability to reach an un-served or underserved MSS/ICM population, e.g., Native Americans.

If an interested party believes they meet one or more of the criteria, they should call (360) 236-3538 for additional information.

Current Provider Expansion

Current approved MSS/ICM providers who wish to expand their current services will be considered under the conditions listed for new providers. The provider shall contact the state staff identified as their county contact to discuss the interest in expanding. If assistance is needed to identify your county lead, please call (360) 236-3538 or see [Appendix III, MSS County Lead and Contact Information](#).

In the reapplication cover letter, May 30, 2003, it states the First Steps MSS/ICM State Staff makes final determination for the need for additional providers in communities. By requesting agencies state their estimated caseload in the Reapplication (Attachment B, Section 2A, page 3) our intention was simply to assess capacity and accessibility in each county. We did not intend to encourage First Steps agencies to expand into multiple counties.

Expectations of Newly Approved Providers or Current Agencies Approved to Expand Service Area

Rapid expansion of Maternity Support Services and Infant Case Management into a community already having a network of MSS/ICM providers can result in duplication of agencies efforts, disruption of community-arranged referral process, possible denial of billings if multiple agencies share the client, and confusion of clients and providers. The guidelines that follow are the basis for good quality client care and for developing and maintaining good community relationships with other First Steps Providers and other community partners.

1. Before a MSS/ICM approved agency begins offering services in a county or community, the agency's coordinator must consult with the Community Service Office of DSHS/MAA, and with existing First Steps MSS/ICM providers in the intended "expansion" county or community to get a sense of the current capacity for providing First Steps services. Learn what the referral process is for that county or community, if one has been agreed upon. Adapt to the community's referral process.
2. Assure client easy access to all the First Steps disciplines, assure your staff have ready access to each other, and that other First Steps providers can contact your staff easily. Consider the following approaches to assuring easy access by clients and staff:
 - a. Provide all the required MSS/ICM disciplines. Have staff capacity to visit clients during pregnancy and in the post pregnancy period. Home visiting is required. You may also provide office visits.
 - b. Have a back-up plan for client services when your staff is not available.
 - c. Maintain local, centralized chart for each client documenting, all MSS/ICM services provided.
 - d. Provide clients and other providers with a 1-800 phone number so that they may contact your agency without making a long distance call to your main office in Tacoma.
 - e. Have a designated physical location/address within the county or community where clients and other providers can access services, not just a Post Office Box. Keep that location/contact information up to date by sending directory information via email to Rebecca.Peters@doh.wa.gov
3. Become a collaborative partner in the First Steps community by:
 - a. Regularly attend local provider meetings in each county in which you are providing services.
 - b. Abide by referral arrangements that First Steps providers in that community have agreed upon.
 - c. Assure coordination of care through regular case conferences and communication among your agency's staff and with any other agency that is sharing your client's care.

- d. If you see that your agency will regularly share clients between agencies, develop a written working agreement with the collaborating agencies in that county.

Assurance Document

Assurances that all provider agencies must agree to in order to become an approved MSS/ICM provider are described in [First Steps Provider Requirements and Administration, Required Assurances](#).

Core Provider Agreement

A signed core provider agreement is required for approved MSS/ICM agencies to obtain a MAA provider number, essential for reimbursement.

The Core Provider Agreement is reproduced over the next few pages as a sample image for viewing.

CORE PROVIDER AGREEMENT

The Department of Social and Health Services (the department) administers medical assistance and medical care programs for eligible clients. The department provides medical assistance or medical care to certain eligible clients by enrolling eligible providers of medical services.

The department reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients. To be eligible for enrollment, a provider must:

- a. Complete the attached enrollment application;
- b. Be an eligible provider and meet the conditions contained in WAC 388-502-0010;
- c. Complete and sign a debarment form; and
- d. Meet all the applicable state and/or federal licensure requirements to assure the department of his/her qualifications to perform services under this Agreement. This includes maintaining professional licensure in good standing without any stipulation in the provider's license.

A provider will be considered a participating provider once the provider completes the above requirements and signs this Agreement, the department issues a provider number, and the provider bills and accepts payment from the department.

As a participating provider in the medical assistance and medical care programs, hereafter known as Provider, the Provider agrees to the following:

1. **Governing Law and Venue.** This Agreement shall be governed by the laws of the State of Washington. In the event of a lawsuit involving this Agreement, venue shall be proper only in Thurston County, Washington.

The medical assistance and medical care programs are authorized and governed by Title XIX of the Social Security Act, Title XXI of the Social Security Act, Chapter IV of Title 42 of the Code of Federal Regulations, Chapter 74.09 of the Revised Code of Washington, and Title 388 of the Washington Administrative Code. The Provider is subject to and shall comply with all federal and state laws, rules, and regulations and all program policy provisions, including department numbered memoranda, billing instructions, and other associated written department issuances in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

2. **License.** The Provider shall be licensed, certified, or registered as required by State and/or Federal law. The Provider will notify the Department within seven (7) days of learning of any adverse action initiated against the license, certification, or registration of the Provider or any of its officers, agents, or employees.
3. **Billing and Payment.** The Provider agrees:
 - a. To submit claims for services rendered to eligible clients, as identified by the department, in accordance with rules and billing instructions in effect at the time the service is rendered.
 - b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the program, except where payment by the client is authorized by applicable WAC. In no event shall the department be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.
 - c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to the department. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.
4. **Disclosure.** The Provider agrees to submit full and complete disclosure on the enrollment application the following:

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- a. Ownership and control information as required by 42 Code of Federal Regulations, parts 455.100 through 455.106;
- b. Identity of any person who has ownership or control interests in the Provider, or is an agent or managing employee of the Provider who has been convicted of any felony and/or convicted of a criminal offense (felony or misdemeanor) relating to program crimes as required by 42 Code of Federal Regulations, part 455.106; and
- c. Any denial, termination, or lack of professional liability coverage, or any change in professional liability coverage, including restrictions, modifications, or discontinuing coverage.

At any time during the course of this Agreement, the Provider agrees to notify the department of any material and/or substantial changes in information contained on the enrollment application given to the department by the Provider. This notification must be made in writing within thirty (30) days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

- a. Ownership;
- b. Licensure;
- c. Federal tax identification number;
- d. Additions, deletions, or replacements in group membership; and
- e. Any change in address or telephone number.

5. **Inspection; Maintenance of Records.** For six (6) years from the date of services, or longer if required specifically by law, the Provider shall:
 - a. Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to the department.
 - b. The Provider shall make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the Provider, for review by the professional staff within the department or the Secretary of the U.S. Department of Health and Human Services. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.
6. **Audit or Investigation.** Audits or investigation may be conducted to determine compliance with the rules and regulations of the program. If an audit or investigation is initiated, the Provider shall retain all original records and **supportive** materials until the audit is completed and all issues are resolved even if the period of retention extends beyond the required 6 year period.
7. **Disputes.** Either party who has a dispute concerning this Agreement may request an administrative review hearing in accordance with applicable WAC.
8. **Termination.** The department shall deny, suspend, or terminate the Provider's enrollment for cause according to applicable WAC. Either the department or the Provider may terminate this agreement for convenience at any time upon 30 days written notification to the other. In the event that funding from state, federal, or other sources is withdrawn, reduced, or limited in any way, the department may terminate this Agreement. If this Agreement is terminated for any reason, the Department shall pay only for services authorized and provided through the date of termination.
9. **Advance Directives.** Hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMO's must comply with the advance directive requirements as required by 42 Code of Federal **Regulations**, parts 489, subpart 1, and 417.436.

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10. **Provider Not Employee Or Agent.** The Provider or its directors, officers, partners, employees and agents are not employees or agents of the department.
11. **Assignment.** The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement, to a third party without the written consent of the department.
12. **Confidentiality.** The Provider may use Personal Information and other information gained by reason of this Agreement only for the purpose of this Agreement. The Provider shall not disclose, transfer, or sell any such information to any party, except as provided by law.
13. **Indemnification and Hold Harmless.** The Provider shall be responsible for and shall indemnify and hold the department harmless from all liability resulting from the acts or omissions of the Provider or any subcontractor.
14. **Severability.** The provisions of the Agreement are severable. If any provision of the Agreement is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.
15. **Certification.** This is to certify that the information provided in support of this agreement is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws. Willful misstatement of any material fact in the enrollment application may result in criminal prosecution. I acknowledge that this is being signed under the penalties of perjury and understand that the department is relying on the accuracy of the information I have presented. I agree to abide by the terms of this Agreement including all applicable federal and state statutes, rules, and policies.

SIGNATURE OF PROVIDER OR OWNER/MANAGER	TITLE	DATE
If provider is a legal entity other than a person, the person signing the provider agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.		
FULL NAME (PRINTED)	PROVIDER SPECIALTY	

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Mail completed Enrollment Application and copies of licenses to:
 Provider Enrollment
 P.O. Box 45562
 Olympia, WA 98504-5562

Questions? Toll-Free 1-866-545-0544

	ENROLLMENT APPLICATION	CURRENT PROVIDER NUMBER []
Provider must notify the Department within seven (7) days of learning of any adverse action or within thirty (30) days of any status changes to information provided in this agreement. A change in ownership cancels this agreement and a new agreement and provider number must be requested. Providers are required to submit copies of current licensure upon renewal.		
<p>PROVIDERS PRACTICING UNDER AN INDIVIDUAL PROVIDER NUMBER: The agreement must be signed by the individual practitioner. Section I and II must be completed.</p> <p>PROVIDERS PRACTICING UNDER A GROUP PROVIDER NUMBER: The agreement must be signed by the Clinic Manager. Section I must be completed for the Clinic Facility; Section II must be completed for each provider practicing under the group number. Additional spaces for Section II are printed on Page 4 of this application.</p> <p>PHARMACIES: The agreement must be signed by the Owner or Manager of the pharmacy. Section II must be completed for each pharmacist practicing under the pharmacy provider number.</p> <p>HOSPITALS: The agreement is to be signed by the Hospital Administrator. Section I is to be completed by the facility.</p> <p>SUPPLY, AMBULANCE, OPTICAL OR TRANSPORTATION COMPANIES: The agreement must be signed by the Owner or Manager of the company. Section I is to be completed for the company.</p> <p>Mail completed Enrollment Application and copies of licenses to: Provider Enrollment, P.O.Box 45562, Olympia WA 98504-5562. Questions? Toll-Free 1-866-545-0544.</p>		
I. TO BE COMPLETED BY ALL PROVIDERS (Complete all blocks, where appropriate.)		
NAME OF OWNER []		EFFECTIVE DATE []
BUSINESS NAME []	BUSINESS TELEPHONE []	BUSINESS FAX []
PHYSICAL BUSINESS ADDRESS []	MAILING ADDRESS []	
TYPE OF PRACTICE []	SPECIALTY []	NCPDP NUMBER []
PROFESSIONAL LICENSE NUMBER []	STATE []	MEDICARE PROVIDER NUMBER []
SIGNATURE OF AUTHORIZED AGENT []		SIGNATURE OF AUTHORIZED AGENT []
II. TO BE COMPLETED BY EACH PROVIDER PRACTICING UNDER THE ABOVE PROVIDER NAME/NUMBER (Please see Page 4 if additional space is needed.)		
NAME []	PROFESSIONAL LICENSE NO. []	STATE []
TYPE OF PRACTICE []	SPECIALTY []	SUBSPECIALTY []
SOCIAL SECURITY NUMBER []	DEA (NARCOTIC) NUMBER []	MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []
NAME []	PROFESSIONAL LICENSE NO. []	STATE []
TYPE OF PRACTICE []	SPECIALTY []	SUBSPECIALTY []
SOCIAL SECURITY NUMBER []	DEA (NARCOTIC) NUMBER []	MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []

III. TO BE COMPLETED BY <u>ALL</u> PROVIDERS		
1.	Has any provider of service included on this agreement ever been convicted of a felony? If yes, please explain, include dates, charges and final disposition of charges. <div style="border: 1px solid black; height: 15px; width: 100px; margin-top: 5px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	Has any provider of service included on this agreement ever been denied malpractice insurance? If yes, please explain, including date(s), of denial and reinstatement date(s) <div style="border: 1px solid black; height: 15px; width: 100px; margin-top: 5px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Does any provider of service included on this agreement have any restrictions placed upon his/her license? If yes, explain, including date(s), of restriction period. <div style="border: 1px solid black; height: 15px; width: 100px; margin-top: 5px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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OWNERSHIP DISCLOSURE	
Please list the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.	
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TO BE COMPLETED BY EACH PROVIDER PRACTICING UNDER THE ABOVE PROVIDER NAME/NUMBER				
NAME []		PROFESSIONAL LICENSE NO. []	STATE []	MEDICARE PROVIDER NUMBER []
TYPE OF PRACTICE []		SPECIALTY []	SUBSPECIALTY []	
SOCIAL SECURITY NUMBER []		DEA (NARCOTIC) NUMBER []		MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []		
NAME []		PROFESSIONAL LICENSE NO. []	STATE []	MEDICARE PROVIDER NUMBER []
TYPE OF PRACTICE []		SPECIALTY []	SUBSPECIALTY []	
SOCIAL SECURITY NUMBER []		DEA (NARCOTIC) NUMBER []		MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []		
NAME []		PROFESSIONAL LICENSE NO. []	STATE []	MEDICARE PROVIDER NUMBER []
TYPE OF PRACTICE []		SPECIALTY []	SUBSPECIALTY []	
SOCIAL SECURITY NUMBER []		DEA (NARCOTIC) NUMBER []		MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []		
NAME []		PROFESSIONAL LICENSE NO. []	STATE []	MEDICARE PROVIDER NUMBER []
TYPE OF PRACTICE []		SPECIALTY []	SUBSPECIALTY []	
SOCIAL SECURITY NUMBER []		DEA (NARCOTIC) NUMBER []		MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []		
NAME []		PROFESSIONAL LICENSE NO. []	STATE []	MEDICARE PROVIDER NUMBER []
TYPE OF PRACTICE []		SPECIALTY []	SUBSPECIALTY []	
SOCIAL SECURITY NUMBER []		DEA (NARCOTIC) NUMBER []		MEDICAID PROVIDER NUMBER []
GENDER (Check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH []	SIGNATURE []		

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NAME [REDACTED]		DOING BUSINESS AS (DBA) [REDACTED]	
ADDRESS [REDACTED]	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) [REDACTED]	FEDERAL EMPLOYER ID NUMBER [REDACTED]	
This certification is submitted as part of a request to contract. The applicable Procurement or Solicitation Number, if any, is [REDACTED]			
Instructions For Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- -Lower Tier Covered Transactions			
READ CAREFULLY BEFORE SIGNING THE CERTIFICATION. Federal regulations require contractors and bidders to sign and abide by the terms of this certification, without modification, in order to participate in certain transactions directly or indirectly involving federal funds.			
<ol style="list-style-type: none"> 1. By signing and submitting this proposal, the prospective lowertier participant is providing the certification set out below. 2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment. 3. The prospective lowertier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances. 4. The terms covered transaction, debarred, suspended, ineligible, lowertier covered transaction, participant, person, primary covered transaction, principal, proposal and voluntarily excluded as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations. 5. The prospective lowertier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, I shall not knowingly enter into any lowertier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated. 6. The prospective lowertier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- -Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions. 7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lowertier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the LIST of Parties Excluded from Federal Procurement and Nonprocurement Programs. 8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings. 9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment. 			
Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion- - Lower Tier Covered Transactions			
<ol style="list-style-type: none"> 1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. 2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal. 			
BIDDER OR CONTRACTOR SIGNATURE [REDACTED]			DATE [REDACTED]
PRINT NAME AND TITLE [REDACTED]			